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ABSTRACT

In 1997, the federal Office of Rural Health Policy awarded 3-year outreach demonstration grants to 45 projects to provide direct primary and preventive health care services to rural residents in 28 states. The grant program allows recipients to test innovative ideas against the challenges of rural health care delivery, such as provider shortages, geographic isolation, growing Hispanic/Latino populations in rural areas, and changing health care funding and delivery systems. Recipients must form a consortium of local and state agencies or institutions to work together toward project goals. All the projects in this funding cycle succeeded in their efforts, but the populations served and the models implemented were extremely diverse. Twenty-two projects focused on the specific needs of infants, children, or adolescents. Among other populations, women were served specifically by 7 projects, minority groups (Hispanics, African Americans, or Native Americans) by 16 projects, and the elderly by 9 projects. Thirteen projects focused their activities in rural schools or used schools as delivery sites. Ten projects provided continuing education opportunities to health professionals or social workers. Health education, health promotion, or disease prevention were the focus of 31 projects, with topics such as substance abuse, smoking prevention, mental health, nutrition, diabetes, and sexuality. Descriptions of the 45 projects include population served, services offered, innovative features, results, potential for replication, plans for continued funding, and contact information. (Contains title and subject indexes, a glossary, and a project locator map.) (SV)

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U.S. Department of Health & Human Services
HRSA
Health Resources & Services Administration
Office of Rural Health Policy

PROMOTING RURAL HEALTH

THE OUTREACH SOURCEBOOK
Volume 7

RURAL HEALTH DEMONSTRATION PROJECTS 1997-2000

March 2001

Health Resources and Services Administration
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PREFACE

The Federal Office of Rural Health Policy (ORHP), Health Resources and Services Administration, is proud to present *The Outreach Sourcebook—Volume 7: Rural Health Demonstration Projects, 1997-2000.*

Since 1991, ORHP has demonstrated national leadership in supporting the development and testing of innovative health care delivery models that hold tremendous promise for rural communities across the Nation. To date we have supported 515 Outreach Grants. *The Outreach Sourcebook* continues this tradition by summarizing the experiences of the 45 grantees funded in September 1997. The stories included in this volume underscore the compelling and challenging health care needs that still exist in rural America. As you will see, these programs are as diverse in their scope as the populations they served.

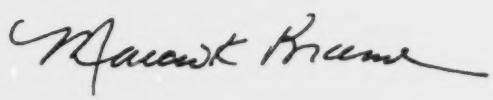
This volume highlights the projects' successes as well as their shortcomings. It also describes the innovative health care access and delivery solutions they tested and how other rural communities can benefit from their experience. Most significantly, it sheds new light on the enormous value of collaboration—not only for the organizations that work together to achieve mutually important goals, but also for the people such organizations are charged to serve and for the community as a whole.

The individual program descriptions that follow are based on project reports developed by the grantees. I believe that *The Outreach Sourcebook* can serve as a valuable resource for every rural community in every State. For rural leaders and future grant applicants, these anecdotes may describe projects that might be replicated in other communities or serve as catalysts for new approaches to rural health care delivery. For health policymakers, these stories are a reminder that our job in rural America is far from over and that rural communities need our ongoing support.

For more information about the Rural Health Outreach Demonstration Grant Program, please call the office at 301-443-0835, or visit our Web site at *www.ruralhealth.hrsa.gov*. For more information about the projects described in this volume, please feel free to contact the projects directly. Each project description includes contact information for your convenience.

I hope you will find the information included in this Sourcebook useful.

Sincerely,



Marcia K. Brand, Ph.D.
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In 1997 the Office of Rural Health Policy (ORHP), Health Resources and Services Administration, awarded Rural Health Outreach Grants to 45 projects located in 28 States. These projects, scattered from Vermont to New Mexico to Alaska, were designed to test and demonstrate innovative models for the delivery of primary medical care, prevention services, and health professions training as well as other health care delivery efforts. Each project funded in 1997 was required to develop a consortium of local and State agencies and organizations so that the fullest range of health care resources could be brought to the communities in which the programs were established.

Together, these projects addressed a broad range of health care delivery challenges. Some of these challenges, such as geographic isolation from services and a shortage of rural health care providers, have existed in rural communities for many years. Others, such as increasing the access to care for rapidly growing Hispanic/Latino populations in rural areas, have emerged in recent years as a result of dramatic and unprecedented changes in the way health care services are organized, financed, and delivered. In all cases, however, each of these projects was able to fashion creative and workable solutions to the unique health care needs of the communities. More important, these consortia succeeded in their efforts to increase access to health care, reduce or eliminate barriers to care, and improve the lives of thousands of rural residents.

All of the consortia created as a result of ORHP's 1997 Rural Health Outreach Grant cycle succeeded in their efforts. However, as the following descriptions show, the key ingredients to their success often varied from one project to another. In spite of the fact that these programs took dramatically different paths and implemented a diverse range of approaches to address local needs, thousands of rural residents whose health care needs had largely gone unmet are healthier, happier, and more productive today than they were before 1997. And their prospects for good health in the years to come are significantly brighter.

The diversity of the following programs—both in terms of the populations served and in the models implemented—cannot be overstated.

- The State of Vermont established a new foster-home-based health service model designed to reduce substance abuse among adolescents in State custody.

- The North Idaho Rural Health Consortium used outreach grant funds to strengthen school-based nursing services in 13 school districts. Nurses not only provide care in the nurse's office but also spend time in classrooms providing health education to students.

- A grantee in northern New Mexico recruited *promotoras* (health educators) from the community to educate local residents about healthier behaviors and the resources and services available to them.

- The Western Dairyland Rural Health Outreach Project in west-central Wisconsin set out to increase access to reproductive health and education services, to establish a children's dental sealant clinic for low-income children, and to create community-based healthy lifestyle and smoking cessation programs.

Program Overview

- Three western New York hospitals joined forces to create a regionally coordinated dental service targeting low-income individuals and families.

- The Health and Wellness Consortium of Western Oklahoma offered culturally appropriate diabetes and hypertension prevention programs in an eight-county area where the Southern Cheyenne and Arapaho reservations are located.

- A school-based health program in South Carolina provided nearly 11,000 units of primary care services and more than 3,100 units of dental screenings to 3,741 students—with the vast majority of services being delivered on school grounds.

- Three projects in the Dakotas used outreach grant funds to develop and enhance emergency medical services.

- The Lewis County Rural Outreach Program in Tennessee targeted low-income residents who did not have money or insurance to pay for mental health, substance abuse, or related support services. Another grantee in Bolivar, Tennessee, launched a multifaceted program to reduce teen pregnancy, low birthweight babies, infant death rates, sexually transmitted diseases, lack of adequate prenatal care, and child abuse.

- The Community Access to Coordinated Healthcare (CATCH) project in southeast Nebraska created a public health nurse-based, toll-free telephone triage service that provided around-the-clock health information and education, referrals, case management, and other resources to help callers access a reliable medical home.

- The Hispanic Adolescent Access Project Network provided health care and mental health services to Hispanic adolescents who are pregnant, parenting, lack insurance, or are inadequately insured.

- The Hale County Mobile Health Clinic offered family planning supplies, screenings, medications, well-child exams, immunizations, nutrition education, STD and HIV counseling and testing, psychosocial assessments, case management, and referrals to residents of west-central Alabama. Similar services were provided by the Wellness on Wheels program in Calhoun, Georgia.

- The Kenai Peninsula Family Support Program worked with 17 schools in Alaska's Kenai Peninsula to identify youth with serious emotional disturbances and to provide culturally appropriate care and support to those youth and their families.

- The "All of Us Be Well" program in northwest Arizona provided culturally relevant community and family activities to residents of the 1-million-acre Hualapai Indian Reservation. Activities promoted increased physical activity and improved selection of low fat, high fiber foods.

- The WARRIORS Health Center project targeted high school students in Tattnall County, Georgia. The project was designed to keep students in school and on track for high school graduation by preventing a second teen pregnancy through case management, mental health counseling, and a Resource Moms support group.

- The NetWORKS Project in Oskaloosa, Iowa, sought to prevent work-related injuries and deaths and to provide case management services for individuals who suffer work-related injuries, including tracking the care they receive and communicating with the injured employee, physicians, rehabilitation services, employers, and insurance carriers until the employee was able to return to work.

- The Rural Prevention Network in Michigan's lower peninsula sponsored a range of tobacco, alcohol, and sexual activity prevention programs based on nationally renowned prevention curricula and campaigns.

- The Dent County Healthy Communities project in Salem, Missouri, used outreach grant funds to create an after-hours, nonemergency care facility, to support school-based social workers, to provide dental and optical services to uninsured children, and to establish a crisis line that provided a single referral source for medical assistance, utilities, emergency shelter, local transportation, and food assistance.

- The Health and Optimum Performance for Everyone (HOPE) program in Missoula, Montana, was created to improve the health status of people with physical disabilities by helping them adopt a healthier lifestyle and reducing the incidence of secondary conditions.

- Project Transcends in Minot, North Dakota, focused on developing and delivering a nursing curriculum using distance education technology for rural communities scattered across 20,000 square miles that were experiencing serious nursing shortages.

- The Elder Care Project in central Nebraska targeted adults aged 65 and older who had self-care, mobility, and transportation limitations. The goal of the program was to enable older adults to remain independent in their own homes and to prevent premature institutionalization and repetitive hospitalization.

- A hospital in Spencer, Iowa, used its outreach grant to provide agricultural health and education services to farmers across the state of Iowa.

- The "I Sing the Body Electric" program in Mattoon, Illinois, used creative arts and peer influence to foster resiliency in youth at risk for substance abuse and other risk behaviors.

These are just a few of the innovative health care delivery and training approaches that were implemented as a result of the 1997 Rural Health Outreach Grant cycle. The good news is that the vast majority of these programs continue to fill a crucial and compelling need in their communities.

These models hold tremendous promise for the delivery of health care in rural areas. In fact, every rural community in every State can benefit from the experiences of these projects and gain new insight on how to address the unique needs of their population.

Each project description contained in this volume includes the name of an individual who was intimately involved with the implementation of the project. The reader is encouraged to contact the identified individual for more detailed information about the project. For more information about the Rural Health Outreach Grant Program or other rural-specific initiatives funded by ORHP, contact Ms. Eileen Holloran at (301) 443-0835 or visit our Web site at www.ruralhealth.hrsa.gov.

AHA	American Heart Association
AIDS	Acquired Immunodeficiency Syndrome
CHIP	Children's Health Insurance Program
CME	Continuing Medical Education
CPR	Cardiopulmonary Resuscitation
ECT	Emergency Care Technician
EKG	Electrocardiogram
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EPSDT	Early Periodic Screening and Diagnostic Treatment
ESRD	End-Stage Renol Disease
HIV	Human Immunodeficiency Virus
IHS	Indian Health Service
MCH	Maternal and Child Health
STD	Sexually Transmitted Disease
WIC	Women, Infants, and Children

Outreach Grants Awarded in 1997

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Population Served

Hale County is located in the Black Belt region of west central Alabama. Some 15,392 residents—many of whom are African American—call Hale County home. More than one-third of the county's residents live in poverty. The per capita income of $12,927 is 59 percent of the national average and 72 percent of the State average. Hale County is one of the 50 poorest counties in the United States.

Many area residents living outside of Greensboro lack access to health care and social services, and many are not aware that local health and social services are available. Some Hale County residents are unable to navigate the current complex health and social service system, and there is a dire shortage of psychosocial assessment and counseling services in local agencies. Some residents lack transportation to specialty or urgent health care services. In addition, because many physicians do not stay in practice in the area for a long time, many residents are unable to benefit from a long-term and trusting patient-doctor relationship.

Services Offered

To address the health care needs of Hale County residents, five local agencies created the Hale County Mobile Health Clinic. The consortium consisted of the Hale Empowerment and Revitalization Organization (HERO) Family Resource Center, the Hale County Department of Public Health, the Hale County Department of Human Resources, the Hale County School System, and West Alabama Health Services. The Mobile Health Clinic traveled throughout the county to bring health care and support services to county residents. The HERO Family Resource Center provided a social worker to offer one-on-one assistance to help families navigate the local health care system, follow up on patient referrals from health and social service providers, and handle psychosocial assessment, counseling, and other referrals. The Hale County Department of Public Health provided a registered nurse, health care equipment, and supplies. The Hale County Department of Human Resources and West Alabama Health Services referred clients to the mobile clinic for social services and medical assistance. The Hale County School System allowed the mobile clinic to come to area schools to provide free

ALABAMA

HALE COUNTY MOBILE HEALTH CLINIC
HALE EMPOWERMENT AND REVITALIZATION ORGANIZATION (HERO) FAMILY RESOURCE CENTER
GREENSBORO, AL

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health screenings to school children and to present educational programs for students and staff. In return, the school system provided routine maintenance for the mobile clinic van, gasoline, and a safe parking space for the van. To supplement these efforts, the consortium also offered transportation reimbursement and launched a public awareness campaign through local schools, media, and speaking engagements.

The services offered by the mobile clinic included family planning supplies; blood pressure and hypertension screening and medications; vision, hearing, and blood sugar screenings; child health exams; immunizations; nutrition education; testing and treatment for sexually transmitted diseases; HIV/AIDS counseling and testing; tuberculosis screening and treatment; health education; psychosocial assessment; case management and referrals; and medication assistance.

Innovative Solutions to Problems

The Mobile Health Clinic was the centerpiece of the project. Medical equipment was installed into a 36-foot Allegro Bay recreational vehicle. The van regularly visited five sites throughout the county. Sites were selected based on population density and the number of patients currently seeking services at the County Department of Public Health who lived on the outskirts of the service area.

Results

Through the school health programs, the mobile clinic provided well-child check-ups to 355 area children in the community. Nearly 450 residents were served by the hypertension medication program, while 238 people received medication assistance. More than 500 residents received psychosocial assessments and/or referrals. In addition, approximately 210 residents received health education at the project's health fairs, and 250 participants were involved in community education programs. Ten patients benefited from comprehensive social services case management.

Potential for Replication

Creating a mobile health clinic may be an ideal solution for rural and other communities with large numbers of geographically isolated residents. One of the best ways to increase access to health care services is to meet people "where they are." Communities should consider, however, that maintaining a mobile health clinic is a challenging and time-consuming endeavor. The vehicle must be built according to the specifications of its intended use. Consequently, local

companies usually were unable to make repairs to the vehicle used by this program. The vehicle often had to be sent back to the manufacturer for repairs. Other rural communities also may find it difficult to recruit and retain qualified professional staff.

A great deal of work must be done in advance—long before a mobile health clinic hits the road. For example, all agencies involved need to delineate their responsibilities and establish a timeline for completion of tasks. In some instances, community agencies may need to establish formal contracts. In addition, prior to the start date the target population must be made aware that a new service exists, what it offers, and how they can use it.

After the Grant

The Hale County Mobile Health Clinic will continue without interruption. However, due to changes in the Medicaid system, child health examinations probably will not be provided in schools. The medication assistance program continues to grow at a rapid pace. The HERO Family Resource Center will continue to provide a social worker for the mobile clinic, and the County Department of Public Health will continue to provide a registered nurse.

Population Served

The Kenai Peninsula Borough is equivalent in size to the State of West Virginia, covering approximately 28,000 square miles. It has 32 separate rural communities and Alaska Native villages, more than 40,000 residents, and more than 700 youth with serious emotional disturbances believed to need behavioral health care services. Distance and limited availability of services, travel time, and cost are all barriers that residents must overcome when they need health care. For children and adolescents with serious emotional disturbances, these barriers often result in their needs going unmet.

Services Offered

Five organizations formed a consortium to plan and implement a new model of service delivery for youth with serious emotional disturbances, and their families, in the borough. This network included three community-based mental health centers, a public school system, and a public nonprofit community hospital that all offered experience in serving such youth and their families. Added to this group of five service providers was the Center for the Study and Teaching of At-Risk Students, a nationally known center for research and services based at the University of Washington.

The main goal of the project was to take services to the clients rather than bringing them to mental health centers. The network decided that the most accessible place for service delivery was the public school setting. School districts identified youth needing services, provided office space, and offered their network system with parents. Services available to students and their families included crisis intervention; individual, group, and family therapy; prevention education; psychological and psychiatric services; summer therapeutic programs; and case management.

Innovative Solutions to Problems

Specially trained mental health specialists working in 17 schools throughout the Kenai Peninsula served students referred by school staff, with parental approval. Mental health specialists had weekly access to group psychiatric consultation and met twice

ALASKA

KENAI PENINSULA FAMILY SUPPORT PROGRAM
CENTRAL PENINSULA COUNSELING SERVICES
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each year with the program evaluator to discuss progress, clarify goals, and re-examine their roles. Principals and faculty at all target schools were fully oriented to the project.

Students received services in a variety of ways. Some children received services as part of their assigned schedule 5 days per week. Others were seen inside their classrooms in small groups. Still others received services after school or during nonacademic class time. Specialists sometimes made home visits and provided transportation to families to help them obtain other services. The main thrust of this school-based mental health program was to provide any service necessary to help young people succeed at school and at home. All services were delivered in a way that was consistent with the project's vision, and existing Medicaid regulations, that support continued funding of services.

Results

The project served 452 youth with serious emotional disturbances. Students who received services were more often male and elementary school age. Approximately one-third of youth served were of Native American origin, and the rest were Caucasian. The project demonstrated that providing school-based mental health services helped students with serious emotional disturbances maintain a stable mental health outlook and positively influenced student behavior at home and in school.

Potential for Replication

This model could work well in other communities that have a funding source to carry on the program after start-up monies are used. In Kenai Peninsula, Medicaid and other third-party fees provided that funding.

The project yielded at least two important lessons of relevance to communities considering such a model. First, staff need to be educated to value data collection and to understand its role in demonstrating success. Second, it is critical that mental health program managers and principals clearly delineate supervisory responsibility for mental health specialists. Addressing these issues early on will significantly increase the likelihood for success.

After the Grant

Services will continue at 14 of the 17 school sites along with 10 pre-existing mental health school-based sites established prior to the outreach grant. All will continue to provide mental health services on school grounds.

Population Served

The Kaibeto Health Services project was created to serve a region of northern Arizona characterized by poverty, virtually no access to basic health care services, and numerous other social and economic barriers to well-being. Approximately 95 percent of area residents are Navajo Indians, and 89 percent lived below 200 percent of the poverty level.

Services Offered

The main goal of the project was to establish a school-based frontier primary care clinic to provide basic primary medical care services. The project also offered training to local first-response units and programs to promote increased physical activity and better nutrition. The project targeted residents of all ages.

The consortium consisted of the Lake Powell Medical Center, a Federal 330 community health center; Kaibeto Boarding School, which included kindergarten through sixth-grade students; Lake Powell Institute, a local mental health agency; the Indian Health Service Kayenta Service Unit; and the Page Fire Department.

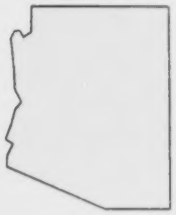
Innovative Solutions to Problems

In addition to providing basic primary health care services, the project offered two CPR classes, a first-responder course, and walking club. The vast majority of those participating in these programs were Navajo people living in the Kaibeto area.

Results

The program provided 3,264 units of primary care services to 1,729 residents. A total of 41 people received CPR training, and 27 people participated in the walking club. Twelve individuals received first-response training. The project served 880 children aged 0 to 11 years, 240 adolescents aged 12 to 19 years, 570 adults aged 20 to 64, and 39 individuals aged 65 and older.

ARIZONA



KAIBETO HEALTH SERVICES
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PAGE, AZ

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Potential for Replication

This project provides a model for leveraging community resources to increase access to basic primary health care services. Locating the services in a school setting offered a means to ensure that area children received basic health care services and to educate parents and other adults about the availability of CPR training, the walking club program, and nutrition and healthy lifestyle education activities. This model may be particularly relevant for communities in which primary care services are extremely limited or nonexistent, and for rural communities with a large ethnic population.

After the Grant

The clinic plans to continue supporting its activities and programs through Federal 330 funds, which enable clients to pay for services based on a sliding scale, and through Medicare and Medicaid reimbursements.

Population Served

The Hualapai Indian Reservation spans nearly 1 million acres and rests along the southern rim of the Grand Canyon in northwest Arizona. Peach Springs, the only residential and commercial center on the reservation, is home to approximately 1,000 tribal members, 700 non-Hualapai Native Americans who are less than one-quarter Hualapai, and 100 non-natives. More than half of the area's population is aged 18 and younger, 66 percent of the potential workforce is unemployed, and more than 15 percent of the employed earn less than $10,000 a year.

Within the Hualapai community, morbidity and mortality attributed to chronic diseases—such as type 2 diabetes, kidney failure associated with diabetes, liver disease associated with alcohol consumption, and cardiovascular disease—are 5 to 10 times higher than the national average. Local providers focus on treatment and have limited time and skills to devote to health promotion and disease prevention programs. As a result, health-negative lifestyle behaviors influenced by family and environmental factors continue to put local residents at increased risk for chronic disease.

Services Offered

Members of the consortium included the Hualapai Tribe's Department of Planning and Community Vision, the University of Arizona's College of Public Health, and the local Indian Health Service (IHS). The tribe was responsible for providing overall management of consortium activities. The University of Arizona offered program and outcome evaluation and contributed to the content and delivery of health education components. The IHS provided health service at various community events and assisted with health education efforts.

The main goal of the "All of Us Be Well" program was to provide the community and families with options for increased physical activity and improved selection of low fat, high fiber foods. Health promotion and disease prevention activities were also offered in local schools, a senior center, summer youth programs, and the local health department.

ARIZONA

ALL OF US BE WELL
THE HUALAPAI TRIBE
PEACH SPRINGS, AZ

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Innovative Solutions to Problems

Programs were specifically designed for the community at large, families, men, women, and youth. Communitywide programs and events included regular exercise and dance classes, offered 5 days a week throughout the day for convenience of participants. Team weight loss competitions were held, along with 16-weeklong 100 mile walking clubs, and health fairs. Programs specifically targeting families included week-long family retreats, offering healthy foods, culturally relevant nature walks, cultural preservation presentations and events, games and team sports, nutrition and healthy cooking education, and family skills sessions. Adult programs included men's and women's gatherings to promote health of mind, body, spirit, and culture; senior center exercise programs, including a training program for the Senior Olympics; cooking classes; and a ropes course. Health promotion and disease prevention programs for youth included school exercise sessions, ropes course experiences, and exercise and nutrition classes during the summer. Local forums and informal discussions offered continuous opportunities for community input, enabling residents to share their ideas with project staff regarding program improvements.

Results

During the grant period, the project sponsored 1,600 exercise classes, 6 weight loss programs, 6 family retreats, 35 ropes courses, 2 100-mile clubs, 5 men's and women's gatherings, and 26 nutrition education sessions. The program sponsored 4 school exercise programs and reached 800 youth participating in summer youth programs. To reach the elderly, the project offered 20 exercise and training programs for seniors and sponsored 9 Senior Olympics events. More than 450 people participated in community walks/runs, and the program was involved in 2 health fairs.

After Year 1 of the project, 65 percent of those surveyed by the program said they were familiar with the project and could name some activities. Preliminary data from Year 3 indicate that 95 percent of the target population were familiar with the project and could name some activities. Activity signup sheets show that more than 50 percent of the community participated in at least one project activity and 55 percent of the adult population aged 20 to 64 years participated in multiple activities.

Potential for Replication

This program would work well in other rural areas with a strong sense of community unity and established social networks. Based on the program's experience, the key to increasing community involvement in physical activity, family strengthening, and nutrition education programs is to make activities fun, reliable, and inclusive. The community demand for such programs can be high, and many rural programs may not be able to meet such demand because of limited staff, resources, and training. Time and money should be invested in training community members to participate in designing and implementing health promotion and disease prevention activities.

After the Grant

To keep the program going, the consortium has pursued additional grant funding and the development of a nonprofit enterprise. As a nonprofit entity, the Rural Wellness Program will offer its facility and services to other tribes and agencies in the region for a fee. Revenue generated through these means will allow the program to continue offering exercise and healthy lifestyle activities to the community.

Population Served

Diabetes is the seventh leading cause of death in the United States and disproportionately affects Mexican Americans, who have a prevalence rate of 10.6 percent compared with 7.8 percent among non-Hispanic Caucasians. Family history and obesity are major risk factors for the development of diabetes. Other factors include a sedentary lifestyle, a lack of understanding of the risk factors associated with the disease, and being uninsured or underinsured.

The Santa Cruz Collaborative Diabetes Project was established in Santa Cruz County, Arizona, which is located on the U.S.-Mexico border. Santa Cruz is the smallest county in the State, with a population of approximately 30,000 people. The majority of the population (72.8 percent) is Hispanic, most of whom are Mexican American. Diabetes is pervasive within the community, as many residents are diabetic or have a family member or acquaintance who is affected. More than one-quarter of the population lives below the Federal poverty level, and more than half fall below 200 percent of poverty.

Services Offered

The project consortium included the Mariposa Community Health Center; Carondelet Health Network and Holy Cross Hospital, the area's only hospital; Southeast Arizona Health Education Center, which provided continuing medical education for providers and health staff and implemented a school curriculum; Nogales Unified School District #1 and Santa Cruz Valley Unified School District #35, both of which assisted in implementation of the school curriculum; and the State Office of Rural Health, Southwest Border Rural Health Research Center, which provided program evaluation. Other agencies and programs that participated in the collaborative were Sodexho Marriott, a school nutrition program; the Mariposa Community Health Center's Women, Infants, and Children (WIC) nutrition and health promotion/disease prevention programs; and local law enforcement agencies.

The consortium's target audience included adults with type 2 diabetes (including pregnant women), second- and third-grade children, and medical and service providers. The primary goal of

ARIZONA

SANTA CRUZ COLLABORATIVE DIABETES PROJECT
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the project was to increase awareness of diabetes, provide education in effective self-management, and give the support necessary to achieve behavior change.

Innovative Solutions to Problems

The project team included a project coordinator certified in diabetes education and two full-time diabetes *promotoras*. The Southeast Arizona Health Education Center developed a nutrition and exercise curriculum for elementary schools and invited local medical providers to participate in diabetes-specific in-service programs and seminars.

The diabetes team developed a referral and intake system to enroll clients in the program. All county medical providers were encouraged to refer clients to the program for education. *Promotoras* were responsible for engaging clients, conducting home visits, providing transportation to and from services, and conducting outreach and educational sessions under the supervision of the project coordinator.

Results

Approximately 2,200 adults participated in the diabetes education classes, and 400 adults received community screenings. Some 175 pregnant women received one-on-one education sessions, and 680 area third-graders participated in school-based nutrition, exercise, and diabetes education sessions. Glucose monitoring, blood pressure, and pulse screenings were provided to a total of 6,000 adults, and approximately 180 area providers received continuing education through the project.

All medical providers in the county are now more aware of diabetes and its complications. Service providers are eager to refer their patients to educational sessions, and many rely on the expertise of the certified diabetes educator and other program staff for advice on nutrition, weight, medication adjustment, and other matters related to diabetes prevention and treatment. In addition, all area obstetric and gynecologic providers refer pregnant patients with gestational diabetes, or those at risk for gestational diabetes, to the program for monitoring and management.

Potential for Replication

The Santa Cruz Collaborative Diabetes Project has already served as the model for two similar projects located on the U.S.-Mexico border. Again, *promotoras* play a major role in reducing or eliminating barriers to care. In replicating this model, other communities may find that clients face a myriad of barriers, including language, literacy, transportation, poverty, immigration status, underinsurance, unemployment, varying degrees of acculturation, and

fragmented or non-negotiable local health care delivery systems. Ongoing and constant follow-up and social support are critical to helping clients achieve and maintain self-management goals. A qualitative report prepared in May 2000 by the Southwest Border Rural Health Research Center suggested that the program succeeded in lowering blood glucose and blood pressure in the project area population by educating patients to control the disease, providing opportunities for contact with others living with diabetes, and demonstrating concern for their well-being.

After the Grant

The certified diabetes educator is committed to remaining in the community and to staffing education classes for adult participants, including pregnant women with diabetes. The Carondelet Foundation has agreed to provide financial support to continue weekly diabetes monitoring clinics at a local senior center. Meanwhile, the consortium is exploring new opportunities for community-based collaboration.

ARKANSAS

HEARTWATCH: SOUTHWEST ARKANSAS RURAL NETWORK FOR DISEASE PREVENTION

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Population Served

At a 1994 meeting of the Community Oriented Primary Care Advisory Council in the tiny rural community of Lewisville, Arkansas, a member suggested that there seemed to be a large number of people in Lafayette County with kidney disease. She asked if anything could be done. Local officials began collecting and comparing data from the Arkansas Department of Health, the National Center for Health Statistics, and Medicare data on end-stage renal disease (ESRD). Controlling diabetes and hypertension are effective ways to prevent ESRD. Data indicated that Lafayette County had higher rates of kidney disease than State and national averages. As a result, HeartWatch was born.

The service area selected for the HeartWatch project was Lafayette, Hempstead, and Nevada counties. All three counties are medically underserved with a large population aged 65 and older. About one-third of the population is African American. Poverty and the lack of insurance are rampant, and many residents have limited education. Death rates from heart disease in these three counties are higher than State and national rates. The small rural hospitals that once served Lafayette and Nevada counties have closed. Only Hempstead County has a hospital.

Services Offered

A nonprofit corporation in Hempstead County that operates six community health centers in southcentral and southwest Arkansas, CABUN Rural Health Services, Inc., served as the lead agency for the consortium. One of its centers, Lewisville Family Practice Center (LFPC), located in Lafayette County, serves the entire county of 9,000 people. At that center the two most common diagnoses are diabetes and hypertension. This is also true in most family practices in southern Arkansas. Other than the LFPC, there is only one other doctor in the county. A second CABUN clinic is the Hope Migrant/Community Health Center (HMCHC) in Hempstead County. The clinic is located on the grounds of the sole federally operated migrant rest stop in the nation and serves Hispanic migrants and seasonal farm workers.

The consortium also included the Area Health Education Center (AHEC), which is located on the Arkansas/Texas border, and Area V of the Arkansas Department of Health, which serves eight southwest Arkansas counties and operates public health units in each.

PROJECT 6—HEARTWATCH: SOUTHWEST ARKANSAS RURAL NETWORK

The primary goal of the project was to increase and expand access to rural health services for a population at risk of chronic diseases like hypertension and diabetes by promoting risk reduction and prevention programs through an integrated health services delivery network of rural providers. Clinical services, health education, intense outreach, transportation to medical services, and assistance in obtaining prescription drugs were provided to underserved and disadvantaged patients with hypertension, and patients and clients at risk for those diseases. Specifically, the program helped clients control their weight, lower their blood pressure, self-manage diabetes, increase exercise, and stop or reduce smoking.

Innovative Solutions to Problems

HeartWatch had originally planned to offer specialty clinics once a month for hypertensive and diabetic patients in each of the three counties. However, it was soon clear that too many people needed services, and needed services often. Some clients came to the clinics every day. To increase access to these services, two health educators provided services at the LFPC and HMCHC clinics. Later, when the project became better known and its effectiveness was recognized, the program created two clinics in public health units and was invited to provide services in a total of eight clinic sites in the three-county area. Self-help groups were established in each of the counties, and those who participated in the groups showed more progress than those who were exposed to health education less frequently. When it became apparent that many patients could not afford the medicine prescribed by the physician, the outreach worker contacted pharmaceutical companies and arranged for clients to receive free medications.

For Hispanic patients served by HealthWatch, language barriers posed a serious challenge. The program sent a health educator to Spanish classes and brought Spanish lessons to clinic staff. When this didn't work, HealthWatch eventually found a health educator with some bilingual skills. As a result, the number of Hispanic patients served by the program increased substantially.

Results

More than 900 patients were served by the HealthWatch program, and 675 patients were seen by a health educator more than once. Seventy percent of clients were female, 49 percent were African American, and 8 percent were Hispanic. More than half of clients were aged 40 to 64, and more than 800 patients received prescription drug assistance. As part of the program's outreach efforts, HealthWatch staff made 3,754 phone calls and mailed information about

the program and its services to nearly 10,000 residents. As a result of the program, 46 percent of clients lost some weight, 46 percent lowered their blood pressure, and 62 percent had improved blood sugar levels.

Potential for Replication

The HeartWatch model could be replicated in almost any rural area. Heart disease and diabetes are killers that threaten every community, but programs like HeartWatch have demonstrated success in improving health outcomes and reducing risk.

After the Grant

The consortium is seeking funding to expand services to three additional counties. AHEC is planning to conduct a clinical trial for patients with hypertension and coronary heart disease. Part of the revenue from the trial will be used to support HealthWatch.

CALIFORNIA

SIERRA MOBILE CLINIC
EL DORADO COUNTY PUBLIC HEALTH DEPARTMENT
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Population Served

At the time of the outreach grant award, most if not all of the physicians practicing in the Western Slope of El Dorado County, California, served only a limited number of MediCal and indigent patients. The only MediCal and indigent clinic in the area, Molina Medical Center, was threatening to close its doors, and the only physician in the area was planning to close his practice. Since there were no viable alternatives for medical care, it was feared that these closures would increase the burden on Marshall Hospital, as more and more MediCal and indigent patients would be forced to seek primary care at the hospital's emergency room or delay seeking help until their illness became acute.

Services Offered

The Western Slope of El Dorado County includes several isolated, rural communities—none of which were large enough to support a medical practice. People who live in the region often lack transportation. To address these needs, the El Dorado County Public Health Department and Marshall Hospital joined forces to create the Sierra Mobile Clinic to offer the community primary and urgent medical care. The clinic provided services 5 days a week—2 days a week in Pollack Pines and 1 day each week in Somerset, Rescue, and Placerville.

Innovative Solutions to Problems

Marshall Hospital owned the mobile clinic, provided medical staff, and coordinated billing. Mobile clinic staff included a full-time family nurse practitioner and a full-time medical office assistant/driver. The health department managed the grant and offered a health advocate who provided case management services, referrals, and outreach. Clinic operations were overseen by a medical director who was available for telephone consultation, chart review, and after-hours services.

Results

Although it took about a year before the mobile clinic could start seeing patients, by Year 3, the project was serving approximately 1,500 patients annually—most of whom had no other realistic source of basic primary health care. The project succeeded in providing a medical home for many of its patients—

especially families who lacked access to care. The leading diagnosis among patients seen at the Sierra Mobile Clinic were acute sinusitis, hypertension, otitis media, allergic rhinitis, acute upper respiratory infection, cough, and acute pharyngitis. The clinic also offered routine infant and child health checks, oral contraception for females, and other prophylactic measures.

Potential for Replication

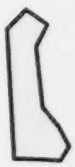
A mobile clinic offers the ability to provide primary medical services to individuals and families living in remote rural areas. However, the size of a mobile clinic also limits the number of patients that can be served simultaneously. While a mobile clinic may not offer the most efficient means for health care delivery, many communities may find that its value—measured by health services provided to people with no other resource—is worth the effort.

It is also important to note that collaboration also requires leadership. This project was inhibited by the fact that the consortium members never developed a unified vision for the project. Individuals from the highest level of each partner organization must be involved in creating a unified mission and providing direction to operational staff.

After the Grant

To sustain the Sierra Mobile Clinic in the years to come, project staff are working to obtain health professional shortage area status for the geographic area served by the clinic and to increase the number of private-pay patients.

DELAWARE



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Population Served

Kent County, the middle of Delaware's three counties, is a rural area with a 1995 population of 121,625. The Hispanic population in the county has grown to about 3,000 people. Median income for single-parent families in Kent County is the lowest in the State. The county also has the highest percentage of children living in poverty in Delaware. At the time of the outreach grant award, health care access was a significant problem as the population-to-physician ratio greatly exceeded national averages.

To address these challenges, Bayhealth Medical Center/Kent General Hospital formed the Central Delaware Community Health Partnership. The goal of this community coalition was to improve the county's health status while reducing duplication of services. From this partnership, four task forces were created, including a Primary Care Task Force. As members of this task force, Bayhealth Medical Center, the Delaware Division of Public Health, and Delmarva Rural Ministries (DRM) began exploring ways to expand primary health care services to the uninsured, the underinsured, homeless individuals and families, and farmworkers.

The task force concluded that the smartest and most cost-effective solution to increasing health care access was to expand DRM's part-time migrant health center to a 12-month operation. As a federally qualified health center, DRM had already established itself as a leading provider of primary health care, nursing-based outreach, and social services to migrant and seasonal farmworkers in central and southern Delaware. The advantages of this approach are underscored by DRM experiences in providing culturally sensitive health care, bilingual staff, and a mobile health unit (the MATCH van) that offered childhood immunizations, health screenings, and other prevention services to at-risk and underserved communities.

Services Offered

Through the outreach grant—coupled with generous seed funding from The Longwood Foundation—the Kent Community Health Center was created to provide comprehensive primary care health care services to persons in central Delaware who lacked a medical home and were uninsured or underinsured. Center case

managers, funded through the Community Services Block Grant, assessed each client's social needs and facilitated the provision of services, including delivery of emergency food, clothing, and basic hygiene necessities. Case managers also provided translation, transportation, and referrals to DRM's rental housing program.

Bayhealth Medical Center/Kent General Hospital agreed to provide stock medications at no cost and offered discounts on diagnostic laboratory and radiology services for the center's patients. The Division of Public Health provided in-kind coverage by its physicians for two evening clinics each week during the center's first year. DRM managed and staffed the center. Because the center was charged to meet the health care needs of all residents throughout the county, clients served by the program crossed all socioeconomic levels.

Innovative Solutions to Problems

In November 1998, DRM contracted with a local physician group to secure full-time coverage at the center, which expanded client access to physician care during day and evening hours. This expansion enabled DRM to participate in the Medicaid managed care program, which provided third-party reimbursements to help support the center's operations.

Results

In its first 3 years of operation, the Kent Community Health Center provided care to nearly 6,000 uninsured and underinsured members of the central Delaware community. More than 300 of the center's current patients have been enrolled in Delaware's 2 Medicaid managed care programs. The center averages 50 new patients per month. These totals do not include the thousands of migrant and seasonal farmworkers who rely on DRM and its services for primary health care.

While one-third of the center's patients were employed, four of five were at or below 100 percent of the Federal poverty level, and nearly nine of 10 of those receiving health care at the center had no medical insurance.

Incidentally, in 1994, Bayhealth determined that about 58 percent of its emergency room patients could have been served in a primary care setting. Since creation of the Kent Community Health Center, Bayhealth has experienced a reduction in the number of non-urgent cases in its emergency room, resulting in less uncompensated care and more appropriate use of resources.

Potential for Replication

The Kent Community Health Center was modeled after other federally funded health centers and can be replicated in other rural areas. Its success, however, was based in large measure on the collaborative efforts of the consortium and the existence of an underutilized but viable nonprofit health center. The Central Delaware Community Health Partnership model has been replicated in other parts of the State. Such consortia bring together a variety of nontraditional partners—community members, health care providers, and others who share the common goal of reducing duplication of services and increasing access to care.

After the Grant

In June 2000, ownership of the Kent Community Health Center was transferred from the Central Delaware Community Health Partnership to DRM. The change allows DRM to more aggressively seek funding commitments from public and private sector sources. The center continues to participate in two Medicaid managed care plans and administers a sliding scale that makes health care more affordable and accessible for the community's uninsured and underinsured. The center also now is using an automated patient management system that offers electronic billing capabilities. Bayhealth Medical Center/Kent General Hospital continues to stock medications and offer lab and diagnostic tests at a discounted rate.

Financial support to sustain the program's future operations will continue from patient and third-party payments, Federal funding for farmworker health care, and ongoing public and private sector support.

Population Served

Long County is a primarily rural county in southeast Georgia. In 1996, the total county population was 6,603—77 percent of whom were Caucasian and 23 percent were African American. More than 70 percent of the population is under age 45, largely because Fort Stewart Army Base is located in nearby Hinesville. Some 21 percent of the population receive Medicaid, and nearly 16 percent receive food stamps. More than 20 percent of the county's residents are below the Federal poverty level. The county has been designated both a medically underserved area and a health professional shortage area. Until recently, when a physician set up practice in Ludowici, the public health department was the only health care provider in the county.

Services Offered

When Long County Rural Health Primary Care Center was created, it was the only primary care service provider in the county. Local residents soon viewed the center as a source of immediate and accessible care. The working relationships between the center, the physician who set up practice in 1998, and the Long County Health Department have been a positive experience and a welcome addition to the Long County community.

On Monday, Wednesday, and Thursday, the center is open from 8 a.m. to 5 p.m. On Friday, operating hours are 8 a.m. to 2 p.m. On Tuesday, the center offers extended hours from 8 a.m. to 7 p.m. Clinic hours have proved to be popular with the working population, but utilization appears to spread evenly across all age groups. The center offers services on both an appointment and walk-in basis. The center offers a broad range of primary care services, including well-child exams, immunizations, pneumonia vaccines, sexually transmitted disease testing, hypertension screenings, health checks, pregnancy testing, family planning, breast exams, and other services.

Innovative Solutions to Problems

During the first year of the grant, it became apparent that the center's space in the community building was too compact to provide good patient care and patient privacy. It was decided to move the center into the adjacent Long County Health

GEORGIA

LONG COUNTY RURAL HEALTH PRIMARY CARE CENTER
LONG COUNTY BOARD OF HEALTH
BRUNSWICK, GA

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Department. In the new facility, the center had more waiting room space and access to health education materials. Health department staff were available to assist center staff during unusually busy times, and the center shares the laboratory with the health department.

The Coastal Medical Assistance Clinic in Hinesville functions as a referral source for the center, especially for those individuals who have no means to pay for physician services or diagnostic tests otherwise.

Results

Despite the original delay in obtaining a Medicaid provider number, the center has become a major primary care resource in Long County. A total of 2,091 patient encounters were documented between May 1999 and February 2000. Of these, 487 patients received family planning services, 341 received well-child exams, and 208 received hypertension checks. While the demand for family planning services remained constant over this period, well-child exams increased 27 percent, hypertension screenings increased 42 percent, and health checks increased 37 percent. The increase in health checks is especially noteworthy because clinic managers at most sites are seeing reductions in these numbers since the implementation of Georgia Better Health Care, a primary care case manager form of Medicaid managed care.

The monthly income projected for the first 7 months of operation (March through September 1998) was approximately $3,922. However, the monthly income for the 7-month period actually averaged only $1,339, a shortfall of 66 percent. Income for the third year did approach the original projection, with an average of $3,100 per month.

Every effort was made to maximize collections. The center worked to increase patient volume, increase reimbursements (private insurance, Medicare, and Medicaid), and expand services needed by the target population.

Potential for Replication

While Long County represents an extreme rural example, this model has the potential to work well in other rural areas. Garnering broad-based community support is imperative to establishing such a clinic and ensuring its success. For example, some physicians and other health care providers may see such a clinic as competition, especially in a small community where providers are few.

After the Grant

In 2000, the nurse practitioner position funded by the outreach grant was transferred to a permanent position with the State Office of Primary Care. This move will help safeguard continuation of the program. Other sources of funding will be pursued as the program grows.

GEORGIA

WELLNESS ON WHEELS (WOW)
GORDON HOSPITAL
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Population Served

The population of Gordon County, Georgia, remains primarily rural—with many residents living in isolated hollows, hillsides, farms, or small crossroads communities. There is also a growing Hispanic population in the county. Many families and individuals do not use the traditional health care delivery system because of geographic isolation, language barriers, educational status, financial constraints, and lack of transportation.

Serviced Offered

The Gordon Hospital Wellness on Wheels (WOW) mobile health van served rural Gordon County residents, providing screenings, blood pressure and cholesterol checks, immunizations, primary care services, physicals, health education, and a range of other services. The van was equipped with a television and VCR so that patients could watch educational videos. The project also made an effort to be visible to the community by being involved in community programs, such as the county fair, health fairs, the annual 5K run, CPR Saturday, and other opportunities to promote a positive public image of the WOW van in the community.

WOW is the collaborative product of several local organizations and agencies, including Gordon Hospital, the Gordon County Health Department, Gordon County School System, City of Calhoun, Gordon County Department of Family and Children's Services, Gordon County Family Connections, and several local industries.

The county school system provided fuel and maintenance for the van. The city school system provided a student intern for administrative support, including filing, typing, and registering patients. The health department provided a nurse, and Family Connections referred children needing medical help and provided the financing for their medications. The Department of Family and Children's Services referred children of adoptive and foster parents for physical exams. Also, the project partners with local industries to provide onsite medical care to their employees.

Through marketing and advertising, the community was informed of the new service, and people began to use it. Over time, WOW gained the community's trust and confidence. The project also disseminated monthly calendars and newsletters to collaborating organizations to keep them informed and involved.

Innovative Solutions to Problems

After each encounter, WOW patients were provided a customer satisfaction form. The questionnaire asked clients how they heard about the WOW program and to rate the services received (on a scale of 1 to 10.) The form also asked whether they were provided additional referrals, whether they understood instructions regarding follow-up services or proper use of prescribed medications, and whether they could access health care elsewhere if they had not come to the mobile unit.

Results

A total of 8,352 patients have been served by the WOW van since it first started operating. More than half of those served were adults aged 20 to 64 years, and 24 percent were aged 65 years or older. Nearly 1,000 clients were adolescents aged 12 to 19 years, and more than 600 were children aged 0 to 11 years.

Potential for Replication

A mobile health unit may provide an ideal solution to the access barriers commonly found in rural areas. It offers versatility and flexibility, and the WOW program is still discovering ways it can be used and new services that can be delivered. The biggest challenge that other rural communities are likely to face in replicating this project is overcoming cultural and language barriers many residents face in accessing quality health care.

After the Grant

The WOW van coordinator succeeded in generating funds to continue the program. The van will continue to provide onsite primary care services to several local industries so employees can receive medical treatment during short breaks or their lunch hour rather than having to miss a day of work. The county school will continue to provide maintenance and fuel for the van as long as the mobile unit provides low-cost health care to needy students. The van has also started providing mandatory physicals for all county and city school bus drivers, plus school and sports physicals for local students.

Consortium members are now working with local officials to explore the possibility of creating a mobile dental care unit. Four local dentists have agreed to donate their time once a week on a rotating basis, and some dental equipment is available from a retiring dentist. The main barrier is locating funding for a fully equipped van.

Population Served

Located in rural southeast Georgia, Tattnall County is home to 18,167 residents living in a geographic area of 488.3 square miles. At least one-quarter of the county population is younger than age 19, and 27.6 percent of these children and adolescents are living in poverty. Much of the poverty is associated with adolescent childbearing. In 1995, 25.8 percent of all births were to females younger than age 20, and some 32.1 percent of these births were repeat pregnancies. The local high school dropout rate in 1994-95 was 10.1 percent, with a high school completion rate of only 62.2 percent.

Services Offered

The WARRIORS Health Center project targeted Tattnall County High School students. The program was designed to keep students in school and on track for high school graduation. The direct delivery of health care services in the county high school focuses on teen pregnancy prevention through case management, mental health counseling, and a Resource Moms support group. The project placed strong emphasis on preventing a second pregnancy and increasing male involvement.

The initial WARRIORS consortium was headed up by the Tattnall County Health Department, which served as the fiscal agent, employed the nursing staff, and provided supervision and nursing protocols. The health department also launched the Resource Moms program. Other consortium members included the Board of Education, which provided space and facilities for the health clinic, the mental health counselor, and the health occupations classes; Pineland Mental Health, which provided a mental health counselor; Concerted Services, Inc., which developed and implemented the male mentoring component of the program; and Family Connection, which assisted in obtaining equipment and supplies and provided opportunities for local information dissemination through its bimonthly collaborative meetings.

A registered nurse provides a broad range of services to the county high school students. These include case management services to females who are pregnant or have been pregnant, and a health occupations course for students considering a career as a certified nursing assistant. The mental health counselor provided

GEORGIA

WELL ADOLESCENTS RETAINING RESPECT, IMPROVING OUTCOMES, AND REACHING FOR SUCCESS (WARRIORS) HEALTH CENTER PROJECT
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services at the school 1 day a week and was available to counsel teens receiving case management services and those who presented an urgent mental health need. The Resource Moms group originally matched pregnant or parenting teens with appropriate mentors. However, due to a lack of prospective mentors, a group mentoring approach was used, and with the cooperation of the principal, the group was permitted to meet during school hours once or twice a month. The male mentoring services program targeted at-risk males aged 9 to 18 to increase self-esteem and improve academic performance and behavior as a means to prevent premature parenthood.

Innovative Solutions to Problems

Most case management services focused on ensuring a healthy pregnancy but cease once the baby is born. The WARRIORS program, however, offered case management services during the prenatal and postpartum phases and continued monthly until the adolescent reached 18 years of age, graduated from high school, or moved out of the county.

Results

During the 3 years of the grant cycle, there were only two repeat pregnancies among pregnant or parenting high school students who had received comprehensive case management services. The program also made significant progress toward achieving its original grant objectives. According to 1998 data, there was a reduction in the countywide pregnancy rate among high school adolescents from 124.1 per 1,000 to 74.3 per 1,000; a reduction in the second pregnancy rate from 32.1 percent to 30.4 percent; and an increase in the percentage of students who graduated from Tattnall County High School from 54.0 percent to 60.2 percent.

During the program, approximately 64 pregnant or parenting teens received case management services. Of these 64 teens, 40 were African American, 23 were Caucasian, and 1 was Hispanic. Some 75 students completed the health occupations course. The Resource Moms group served nearly 20 pregnant or parenting teens, while male mentoring services were provided to an average of 55 students per school year.

Potential for Replication

Teen pregnancy is not unique to Tattnall County. Rural communities across the Nation are struggling with this challenge. This model, however, may be an ideal solution for rural and other communities seeking cost-effective, innovative methods that do not directly involve contraception but instead focus on

preventing repeat pregnancies through intensive case management, group mentoring, and mental health counseling. Preventing the first pregnancy presents a more formidable challenge. However, by promoting the cultivation of responsible and healthy behaviors in pre-adolescent males, other communities may see reductions in the incidence of risky behaviors and early sexual encounters.

While these activities could be implemented in other communities, it is critical that public health agencies, school systems, mental health professionals, and faith communities work in close partnership to achieve mutual goals and objectives. Potential challenges that other communities may face include difficulty in recruiting and retaining mentors because many who express interest in mentoring already have too many commitments. In addition, covering the costs of such programs may present a serious challenge for projects that do not generate revenue.

After the Grant

The state of Georgia has provided limited funding for school nurses to provide case management services for pregnant and parenting teens, and possibly continuation of the Resource Moms program. The health occupations course is being funded by the Tattnall County Board of Education. Concerted Services has secured grant funding to continue its after-school program using many of the same concepts employed in the male mentoring program, and the Family Connection collaborative has received funding for a countywide abstinence program. Unfortunately, mental health services will no longer be offered because of a lack of funding.

IDAHO

NORTH IDAHO SCHOOL NURSING SERVICES COOPERATIVE
NORTH IDAHO RURAL HEALTH CONSORTIUM
SAND POINT, ID

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Population Served

The national average nurse-to-student ratio is one nurse per 750 students. In the 13 school districts targeted by the North Idaho School Nursing Services Cooperative, the ratio was approximately one nurse for every 6,000 to 8,000 students at the time of the grant award. Some of the school districts already had nurses in place. However, many school nurses needed to update their knowledge and skills. Others were not being used as effectively as they could be.

The majority of students in the service area were Caucasian. However, five of the 13 school districts in the area had large numbers of American Indian students from the Coeur d'Alene, Kootenai, Shoshone, and Benewah Tribes. In recent years, large numbers of migrant workers have moved into the area. Some 15 to 21 percent of the area's residents rely on Medicaid for health care services. The region's unemployment rate is about 7 percent.

While the ethnic and cultural diversity of the region is rapidly increasing, area residents have at least one thing in common—they value their independence. Many parents in the area do not want their children receiving sex education in schools. Consequently, for a school nursing program to succeed, school nurses and other personnel would need to better understand, respect, and appreciate the cultural beliefs and expectations of families.

Services Offered

The School Nursing Services Cooperative consisted of Boundary Community Hospital, Bonner General Hospital, Kootenai Medical Center, Shoshone Medical Center, Benewah Community Hospital, Benewah Medical Center, the Panhandle Health District, North Idaho College, and 12 school districts. The primary goal of the consortium was to improve the effectiveness of school nursing services by standardizing policies and protocols for medication delivery, emergency care, and care plan management of medically fragile and at-risk students, and to provide care plan management for vulnerable children in the public school system. The consortium also sought to improve communication between the public health district, public schools, hospitals, and primary care providers to ensure that health conditions are identified and properly treated, and that

immunization schedules are completed for rural school children; and to provide enhanced teacher in-service education plus expanded curricula for health education and health career development through distance learning.

Grant funds were used to hire additional nurses, to secure contracted services from licensed professionals, and to purchase needed medical equipment and supplies, such as beds, first-aid kits, stethoscopes, scales, and recovery couches. Funds were also used to provide a broad array of professional development programs for nurses and educators, and to purchase books and other publications for nurses, students, parents, and school personnel.

The services offered to students varied from one school district to another. However, strong emphasis was placed on helping children receive the recommended immunizations; vision, scoliosis, dental, and blood pressure screenings. Health education programs were also offered concerning HIV/AIDS, basic life support, diabetes, head lice, maturation, alcohol poisoning and binge drinking, and tobacco.

Innovative Solutions to Problems

One innovative feature of the program is that school nurses not only provide medical care, but also spend time in classrooms providing health education to students. Teachers and other school staff reported that nurses are more accessible and always willing to help, which enables teachers to spend more time teaching rather than trying to provide first aid or arrange for health screenings. Nurses also play a key role in educating students and teachers about health issues.

Results

Though not required by the grant, the Consortium asked a local firm to conduct an evaluation of its services and outcomes. Evaluation participants agreed that school-based services improved significantly as a result of the grant and that the grant played a major role in increasing the availability and accessibility of high-quality, school-based nursing services. School superintendents reported that an increase in staff training has enabled nurses to help provide health education training in classrooms, in part due to a substantial improvement in the nurse-to-student ratio. In Year 1 of the grant, two-to-three nurses were available to serve approximately 29,000 students. In Year 3, approximately five nurses were available to meet the needs of the 29,000 students.

School personnel indicated that hearing, vision, and other screenings—as well as immunizations—have been completed as recommended and that there was a reduction in incidences of head lice. There was also an increase in the number of first-aid supplies and equipment.

The range of services offered by the school districts—and the subsequent accomplishments—vary significantly. For example, the Coeur d'Alene school district provided in-service training for staff, alcohol and binge drinking classes, and a support group for students with diabetes. The Lake Pend Oreille school district provided first aid and CPR classes to 90 staff members, 150 high school students, and 200 students in grades 4 to 6. The Lakeland school district established a nursing network in five northern counties and created a "Standards of Practice" manual and first aid flip charts. The Plummer/Worley school district established a self-esteem and refusal skills-building program for 7th graders, and sponsored a "Baby-Think-It-Over" parenting simulation program for grades 7, 10, 11, and 12.

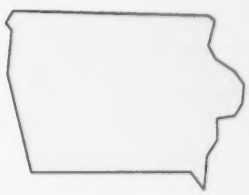
Potential for Replication

This grant resulted in the development of several models that merit replication elsewhere. The consortium's approach of establishing a nursing network to serve 13 geographically dispersed school districts is a model that holds promise for other communities that currently lack school-based nursing services. Likewise, the health education materials and in-service training programs sponsored by the school districts themselves may be replicable in other school districts.

After the Grant

There is resounding agreement that the school nursing services program should continue. Principals, educators, and secretaries who participated in the evaluation indicated that schools still need more nursing time, more in-service training for staff, and more help controlling instances of head lice. In the meantime, the school districts are considering a range of new health education initiatives, including asthma, hand-washing, and nutrition education for students.

IOWA



MARSHALLTOWN COMMUNITY/ SCHOOL HEALTH OUTREACH PROJECT
MARSHALLTOWN COMMUNITY SCHOOL DISTRICT
MARSHALLTOWN, IA

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Population Served

Marshalltown, Iowa, is a rural community that has experienced dramatic changes over the past 15 years. When two major industries moved to other parts of the country, high paying jobs were lost. However, a decade ago, a meatpacking plant expanded its operation to Marshalltown, and as more jobs became available, an unprecedented number of Hispanic families moved into the area. Over the past 8 years, the area's Hispanic population has increased 300 percent. The minority population of the school district more than doubled from 9.5 percent in 1994 to 22 percent in 1999. Many of those families lacked health insurance, and physicians and dentists in the community were not taking new patients. Moreover, families could not apply for health insurance until they had been on the job for 6 months. To compound the problem for school-aged children, the health insurance policy offered by the meatpacking plant did not cover physicals after age 4. As a result, physicals and immunizations required for kindergarten, sports, or local camps were not covered by private insurance.

Although school nurses began to identify more and more children needing health and dental care, accessing such services was extremely difficult. Emergency services were cost prohibitive for families with no coverage. Other barriers included lack of transportation, no telephone at home, parents working days or nights (or both), language barriers, many extended family members living in small homes, and limited financial resources.

Services Offered

Outreach grant funds were used to implement a school-based health program designed to improve the overall health status of school-aged children and to teach families how to access medical and dental services in the community. The program consisted of five components: (1) a mobile primary health care clinic, (2) dental services, (3) an emergency prescription fund, (4) a Health Report Card, and (5) two school nurse positions. The program was open to all school-aged children. However, to avoid duplication of services available from local family physicians and the local Well-Child Clinic, services were limited to children who

did not have a family physician or dentist, those who did not have health or dental insurance, and Medicaid-eligible children who could not find a physician to meet their needs.

The consortium included the Marshalltown Community School District, Marshalltown Medical Surgical Center, McFarland Medical Clinic, Marshall County Public Health Agency, Marshall County Child Health Services, Marshall County Dental Society, University of Iowa College of Pediatric Dentistry, and local pharmacies. Together, these organizations and individuals ensured that all unserved and underserved school-aged children received high-quality health and dental services through a school-based approach.

Innovative Solutions to Problems

The Healthy Start School Clinic provided mobile, school-based preventive and primary health care. It was staffed by a certified pediatric nurse practitioner, a health aide, a secretary, and an interpreter. The clinic rotated through four elementary schools 4 days a week. The two school nurses were placed in schools with the highest number of minority students, and they identified students who had no physician or dentist and needed medical or dental referrals. The school nurses provided health assessments, vision and hearing screenings, weekly fluoride treatments, and basic health care. They also provided a range of health education sessions on handwashing, growth, development, nutrition, and drug, alcohol, and tobacco prevention information.

Physicians, dentists, and University of Iowa College of Dentistry providers were reimbursed for their services at the Medicaid rate using grant funds. A cap of $300 for medical and dental services per child per year was established so that more children could be served.

The emergency prescription fund was used for children who had no means to pay for prescriptions written by the school clinic or a family physician. The Health Report Card created a two-way communication between parents and the school nurse regarding the health status of the student. The form provides the school nurse with information about the student's need for a physical exam or dental exam, general health status, medications, immunizations, and health and safety promotions. At the end of the school year, parents receive a one-page summary of the care their child received and any concerns noted by the school nurse. The Health Report Card is written in English and Spanish.

Results

During the grant cycle, the mobile health clinic served 1,246 children who received 3,111 units of services. Some 36 percent received sick-child care, 29 percent received well-child physicals, 23 percent received immunizations, 6 percent received treatment for dental problems, 4 percent received athletic physicals, and 1 percent received care for vision problems. In all, 25 percent of children in the school district received medical assistance through the mobile health clinic.

Some 1,336 children received dental services through 2,108 appointments, and 276 prescriptions were paid for using the emergency prescription fund. All 5,000 children in the Marshalltown Community School District were given a Health Report Card that tracks their health status from kindergarten through 12th grade.

Potential for Replication

This model requires a tremendous amount of coordination and collaboration. Each agency and school district must be willing to contribute to the program—whether it consists of staff resources, time, supplies, equipment, and/or funding. Most importantly, school districts must value the role of school nurses and believe that healthy children learn better. In addition, school staff must be willing to learn how to identify children in need and meet their needs.

After the Grant

The program has not yet secured enough funding to continue the mobile clinic program. However, Marshalltown Medical Surgical Center has allocated $40,000 to continue the medical and dental components of the program. McFarland Clinic has agreed to serve children for the first year after the grant without reimbursement. Both the Marshalltown United Way and Rotary Club have contributed funding, and the consortium is seeking additional resources from community organizations, grants, and foundations.

IOWA

NETWORKS
MAHASKA COUNTY HOSPITAL
OSKALOOSA, IA

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Population Served

The NetWORKS project was designed to serve a diverse population of individuals aged 18 to 75 years. The target service area, which consisted of three rural counties in south-central Iowa, included mostly Caucasian individuals and families; however, a large number of Hispanics (mostly of Mexican origin), African Americans, Native Americans, and Asian Americans also live in the region.

Services Offered

The principal activity funded by the grant was the development of occupational health and safety programs for local businesses and industries, to enable employees and employers to access much-needed health care services generally available only in more heavily populated communities.

The consortium consisted of Mahaska County Hospital, which administered the grant, Monroe County Hospital, and Knoxville Area Community Hospital. Using grant funds, the project provided occupational health and agricultural-related courses for nurse managers and hospital administrators. Some of the courses offered included audiometry and spirometry training, as well as first aid/CPR instructor courses.

Innovative Solutions to Problems

The central goal of the program was to prevent injuries and deaths and provide case management services for individuals who suffer work-related injuries, including tracking the care received and communicating with the injured employee, physicians, rehabilitation services, employers, and insurance carriers until the employee is well enough to go back to work. In addition, the project provided drug testing, hearing tests and screenings, spirometry/pulmonary function testing, pulmonary fit-testing, wellness screenings, agricultural-related screens, first aid/CPR, and bloodborne pathogen classes, as well as worksite analyses for ergonomic purposes.

Results

NetWORKS served approximately 2,800 males and more than 700 females. The majority of those served were aged 20 to 64; however, the project also served 400 people aged 65 and older. Several racial/ethnic minority groups, including Mexican Americans, Native Americans, African Americans, Bosnians, Asians, and other groups, have been served by the project. Income levels of those served ranged from $12,000 to $150,000 per year. In addition to serving employers and employees in the three-county target area, the project also provided services to clients from Missouri, Minnesota, and Wisconsin.

As part of the training component, five nurses and one hospital administrator received AgHealth Nurse Certification, and four nurses and one administrator completed spirometry and audiometry training. Four nurses also completed the first aid/CPR instructor course. Completion of these training opportunities will enable the nurses and administrators to teach first aid and CPR to groups throughout the community and to provide their audiometry and spirometry expertise to area businesses.

Potential for Replication

This project model is relevant to communities that lack a viable source for occupational health and safety education and services. After the initial investment of resources, such programs can generate enough revenue by serving area businesses and industries to sustain themselves.

After the Grant

Project staff will continue to work together to maintain the programs funded by the outreach grant. Anticipated income for the three facilities combined during the first year after the grant is expected to be $100,000, with higher revenues being generated in the years to follow.

The three consortium hospitals are working with another area hospital to recruit two or three orthopedic specialists for the south-central Iowa region. The consortium members will continue to work together on other projects as opportunities present themselves.

IOWA

EXPANDING ACCESS TO AGRICULTURAL HEALTH SERVICES FOR IOWA FARM FAMILIES
SPENCER MUNICIPAL HOSPITAL
SPENCER, IA

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Population Served

Central and western Iowa are characterized by flat terrain that provides an ideal environment for farming. Southern Iowa, however, has rolling hills, also used predominantly for farming, but conducive to tractor rollovers and other farming accidents. Many Iowa residents are lifetime farmers who depend on the farming industry for their livelihood.

A focus group of Iowa farmers conducted in December 1996 revealed that farmers typically access health care services only when they are ill or severely injured. Although farmers agreed that preventive agricultural health services were needed, it was clear that successfully motivating farmers to seek preventive services would require aggressive outreach and education. In addition, most local health care providers lack specific training in agricultural health.

Services Offered

To address these challenges, a consortium of six rural hospitals and Iowa's Center for Agricultural Safety and Health (I-CASH) at the University of Iowa joined forces to increase access to agriculturally based preventive health and safety services among farmers, their families, and their employees. Services were provided to farmers, family members, and farmworkers throughout the state of Iowa.

In addition to the provision of direct health care services, I-CASH staff provided training to nurses and other health care providers (respiratory therapists, physicians, and other professionals) in the field of agricultural health.

Innovative Solutions to Problems

This project was built on four innovative strategies: (1) involve businesses as a means to ensure financial sustainability, (2) provide training to enhance the skills of health care professionals, (3) promote collaboration among health care providers, and (4) proactively recruit farmers to participate in preventive health services.

For example, although businesses have an interest in becoming partners in the delivery of health services, few prevention-oriented programs consider establishing a collaborative relationship with businesses. Involving businesses was seen as the means to achieve

program sustenance after the grant ends. At the same time, the project was designed to increase the number of health care providers adequately trained to provide comprehensive agricultural health services to farmers, built upon the I-CASH training program, which has been replicated in several States.

The project fostered collaboration among health care providers so that practitioners not adequately trained in agricultural health would recognize their limitations and make appropriate referrals to the agricultural health clinic. At first, the network clinics frequently referred patients to primary care physicians for treatment of elevated blood pressure, abnormal cholesterol levels, and respiratory problems—while primary health care providers rarely referred clients to agricultural clinics. Only after physicians received specialized training in agricultural health did the program begin to document an increase in referral rates by physicians.

Program planners also recognized that farmers often participate in prevention programs only when they have motivation to do so. To eliminate this barrier, program staff brought preliminary screening services to farmers at the settings where they normally interact—farm commodity group meetings, county fairs, pesticide applicator trainings, and other farm-oriented events. These screenings served as an outreach mechanism by which to refer farmers to comprehensive preventive health services offered by trained agricultural health nurses at clinic sites.

Results

Data collected by the project indicate that it reached a larger number of farmworkers and family members than originally anticipated. During the 3 years of the grant, 10,522 farmers were reached at local farming-oriented events, while an estimated 14,500 were reached at State events. Preventive health care screenings were provided to a total of 260 farmers and family members. Of those served, approximately 60 percent were male, and 40 percent were female. The largest numbers were adults aged 20 to 64 years; however, the program also served approximately 5,000 persons aged 65 years and older, 2,000 adolescents, and some 250 children aged 0 to 11.

In addition, a total of 87 health care providers received training in agricultural health, while 1,925 health care providers participated in State and national agricultural medicine training. As a result of the I-CASH trainings and continued technical assistance, 20 new AgriSafe health clinics were established throughout the State.

The fluctuating farming economy continues to create a barrier to the delivery of agricultural health services. During the grant period, the cost of health insurance for many farmers increased by 30 percent each year. The average premium paid

by farmers for family coverage was $3,569, with an average deductible of $1,514 and an average co-payment of 15 percent. With the development of local business partnerships, it is expected that network clinics will continue to reach farmers who are otherwise required to pay out of pocket for preventive care.

Potential for Replication

Most agricultural States in the United States have an infrastructure for agriculture and health care that is similar to Iowa, involving public and private institutions, rural hospitals, health departments, and clinics that serve the farming community. That being the case, this project could work well in other agricultural communities.

The most important aspect of replication is the training of health care professionals in the field of agricultural health. I-CASH offers the only known comprehensive training program in agricultural health. Other communities would either have to establish a similar training program or send their professionals to Iowa for training. Once providers are trained, a community could begin to implement this model.

After the Grant

The Iowa Agricultural Health and Safety Network will continue to function after the grant. Each of the local network hospitals and clinics will assume responsibility for generating their own funding, with minimal assistance from I-CASH for networking activities. During the grant period, many clinics have developed the capacity to sustain most or part of their service components. I-CASH will continue to provide training, technical assistance, and a range of services, many of which will be funded by newly appropriated State and Federal funds

ILLINOIS

RURAL HEALTH PARTNERSHIP
ABRAHAM LINCOLN MEMORIAL HOSPITAL
LINCOLN, IL

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Population Served

Logan County is located in central Illinois and has a population of nearly 32,000, with about half of those individuals and families living in Lincoln, the county seat. A largely rural area, only three physicians practice in the county—one each in Lincoln, Atlanta, and Mt. Pulaski. Abraham Lincoln Memorial is the county's only hospital.

The Rural Health Partnership was created in 1997 by the Healthcare Committee of the Lincoln-Logan Chamber of Commerce. In 1996, the Logan County Health Department, as part of the Illinois Program for Local Assessment of Need survey, determined county residents had several health care needs that were going largely unmet—lack of access to health care; high rates of heart disease, diabetes, and cancer; and for teens, pregnancy, and alcohol and tobacco use. These findings were reinforced by a later survey conducted by the local Chamber of Commerce.

Services Offered

Key players in the Rural Health Partnership included Abraham Lincoln Memorial Hospital, the Logan County Health Department, Logan Mason Mental Health, the Family Medical Center (a physician group practice in Lincoln), and the Chamber of Commerce. This group of visionaries developed and implemented a mobile health unit to visit communities throughout the county and to provide alcohol, tobacco, and drug prevention education programs for local seventh and eighth graders. The hospital served as the grant administrator and "home base" for the partnership. The hospital also covered the unfunded expenses to maintain the mobile unit and the project director's salary and benefits. The health department and medical center provided mobile health unit staff, and the mental health office provided the prevention specialist for the school-based alcohol, tobacco, and drug prevention education programs that focused on self-esteem, resistance to peer pressure, and conflict resolution.

Services provided by the mobile unit included primary and preventive health care, health education, and chronic disease management. Community education programs covering a variety

of topics were offered to county residents, and a strong base of volunteers provided transportation for residents who could not drive or walk to the mobile unit.

Innovative Solutions to Problems

The mobile unit visited two sites daily and provided most of the same services available at the central office of the Logan County Health Department, including blood pressure, glucose, and cholesterol checks; immunizations for children and adults; injections; and environmental health services such as lead and radon kits and water and fluoride samplers. The nurse practitioner offered chronic disease management, primary and preventive health care, education, and counseling. No appointments were required. Health Department clients were required to pay at the time of services, and clients of the nurse practitioner were billed by the medical group. Low-income clients were aided in applying for assistance (e.g., the Children's Health Insurance Program, Medicaid, and Veteran's assistance). No one was ever denied services because of inability to pay.

Results

Residents of the communities served came to rely on the mobile unit for a variety of health services. In addition to depending on the mobile unit for routine monitoring, disease management, and health care education, many residents used the opportunity to consult with staff regarding medications, environmental services (e.g., well water test kits), childhood immunizations, and school physicals. Every month, new patients arrived for services, many of whom would not have received health care unless a visit to the hospital emergency room became necessary.

Alcohol, tobacco, and drug education programs were so popular that the program was expanded to include Lincoln schools. Some 368 class sessions reached 979 students. Pre- and post-test scores indicate a 27-percent increase in knowledge among seventh graders and a 47-percent increase in knowledge among eighth graders. (Most eighth graders had also received instruction in seventh grade, so the latter score is viewed as somewhat cumulative.)

Community education programs offered by the partnership included two special promotions on breast cancer, a prostate cancer screening funded by the Illinois Department of Public Health, and six farm safety events where free tetanus shots were provided to participants.

Potential for Replication

Providing health care via a mobile unit is not necessarily a new concept. However, for a mobile unit to achieve its intended goals, consortium partners must be willing to put personal or corporate agendas aside and focus on the shared mission of the partnership. Such a service must also work in close cooperation with local physicians and other health care providers, county and local governments, and members of the community. This approach will help reduce "turf" concerns and ensure that the service is responsive to the community's needs.

After the Grant

The partnership plans to continue operation of the mobile health clinic and is exploring opportunities for expansion. For example, consortium members are considering ways to work cooperatively with dental, vision, and podiatry professionals in the area, as well as opportunities to expand the mental health component of the program. Fundraising campaigns are currently under way to establish a $3 million endowment for the program. More than $1 million has already been raised.

ILLINOIS

I SING THE BODY ELECTRIC
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Population Served

Although substance abuse prevention efforts in Illinois have been greatly enhanced by the development of a statewide prevention network and the community-based prevention strategies of the Illinois Department of Human Services, such resources are scarce in east-central Illinois. In 1998, the "I Sing the Body Electric" (ISBE) coalition administered the Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey (YRBS) to 4,430 high school students, or 55 percent of the high school population in a seven-county area. Survey results showed that east-central Illinois youth had significantly higher rates of cocaine use (11.9 percent compared with 6.7 percent in the State and 7 percent nationally) and inhalant use. Injection drug use was also higher in the sample than in State and national samples. Of those who were sexually active, only 24 percent reported using condoms compared with 54 percent of youth nationally, leaving area young people at high risk for premature parenthood, HIV infection, and STD transmission. Drinking and driving was reported by 22 percent of the sample—5 to 9 percent higher than State and national figures. Binge drinking was higher for both male (39.9 percent) and female (32.1 percent) study participants than in Illinois (32.5 percent for males and 26.8 percent for females) and in the Nation (36.2 percent for males and 28.6 percent for females).

The survey findings demonstrated an urgent need for a community-based prevention program.

Services Offered

ISBE was created to connect youth with health and education communities in seven counties. Partners included two regional hospitals, the regional superintendent's office for the seven-county area, a State university, a community college, and a local network television affiliate. The ultimate goal of the program is to encourage area youth to make health-positive lifestyle choices.

The coalition's prevention philosophy was built on the proven efficacy of using creative arts and peer influence to foster resiliency in youth at risk for substance abuse and other unhealthy behaviors. Year 1 of the program focused on identifying the issues of primary concern for area youth, including substance use,

drinking and driving, sexuality, and suicide. Year 2 focused on the development of health-positive messages communicated via an arts-based prevention program. Students were mentored by health professionals and university interns in art, music, theater, English, and speech communication. Their talents were showcased at the Arts and Health Festival in April 1999. In year 3, the project sponsored a regionwide school and community tour. Student-created prevention messages also provided the content for a series of television and radio public service announcements that were broadcast throughout the region.

Innovative Solutions to Problems

The project's greatest asset may have been the university interns who worked with high school students to plan and execute their arts-health projects. Because the university students are close in age to the high school population, their interaction was dynamic and exciting. The interns were also responsible for identifying arts mentors from the community to become part of a team to work with high school students on their arts-health projects.

Results

Student arts-health projects demonstrated variety, innovation, and quality. They also provided a creative way to communicate prevention messages to peers, parents, and communities throughout the region. More than 400 students in 26 schools who developed the 100 arts-health projects were awarded $10,000 in minigrants. About 800 people attended the Arts & Health Festival, and $16,000 in prize money was awarded.

The regional tour occurred in many forms—ranging from a full art exhibit with live and video performances, to individual classroom study and discussion, to presentations at teacher-parent programs, and State and national professional conferences. Between April 1999 and May 2000, 17,000 people of all ages were exposed to the regional tour. In addition, art exhibits featuring the students' work have been installed at two regional clinics. Approximately 265 people, including a large number of teenagers, are exposed to these exhibits each day.

Many area teachers have incorporated the program into their classroom learning and activity units, and the program coordinator has been invited to speak to community prevention groups, parent-teacher associations, and civic organizations, and to host arts festivals about the ISBE tour. A model parent-child communication program is being developed with support from area corporations willing to serve as model sites.

In addition to receiving a national health education and promotion award from the CDC and the Association of State and Territorial Directors of Health

Promotion and Public Health Education in June 2000, ISBE has been recognized by the Illinois Principals Association Partnership, the Eastern Illinois University Graduate School, and the local chapter of a national health education fraternity at Eastern Illinois University.

Potential for Replication

Young people found this program energizing, stimulating, and empowering An effective arts and prevention program can be implemented on any scale in almost any community—as long as adolescents "buy into" the benefits and opportunities it presents and the coalition partners are committed to the project. ISBE was fortunate to be located in a geographic setting in which the resources of two State educational institutions were available to the program.

After the Grant

While rural health outreach grant funding is no longer available to the project, ISBE has 2 more years of funding from the U.S. Department of Justice and the Illinois Department of Transportation. The program has also developed a business plan for marketing the project and offers workshops for urban and rural community leaders interested in replicating the project.

KENTUCKY

LOURDES RURAL OUTREACH SERVICES FOR THE ELDERLY AND DISABLED (ROSE)

LOURDES CENTER FOR HEALTHY LIVING

PADUCAH, KY

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Population Served

The counties of far-western Kentucky are among the most rural in the State. They also have the highest average ages. At-risk and isolated elderly and disabled residents face many critical health care issues and limited access to appropriate care. Typically, elderly and disabled persons in the region access the health care system only after a situation becomes acute and the cost of emergency services is high, or when it is too late to be effective. The population generally does not make self-referrals to primary care physicians or mental health clinics. This often results in higher costs, longer recovery or poor rehabilitation outcomes, and premature nursing home placement. These challenges are magnified by shortages of transportation, family caregivers, primary health care providers, and preventive services targeting elderly and disabled persons.

Services Offered

The Lourdes Rural Outreach Services for the Elderly and Disabled (ROSE) program involved the collaboration of five western Kentucky agencies and organizations. The Lourdes Center for Healthy Living is a Catholic nonprofit acute hospital located in Paducah that provided the project manager, an office coordinator, dedicated headquarters for the ROSE project, and the toll-free number for referrals. The Purchase Area Development District provided 1.5 case managers and office space for technical support. The Purchase District Health Department, which already had health centers in each of the counties, provided training for volunteers, gatekeeper training in the designated counties, and technical assistance in writing program brochures and training materials. Both the U.S. Postal Service Letter Carriers Union and BFI/WI Waste Systems provided time and space for training postal carriers and route workers who committed to calling the toll-free telephone number when they identified an individual in need.

The ROSE project offered an emergency response system, which provided immediate response for unexpected emergencies while caregivers were unable to be with their loved one; transportation to and from services; home repairs and modifications; gatekeeper training for persons charged to refer

high-risk elderly (postal carriers and waste management route workers); and a one-stop, toll-free referral service for referrals to services in all eight counties.

The first year of the project targeted the six most rural counties and those that had a growing absence of a young population plus a larger number of seniors lacking family support (Ballard, Carlisle, Fulton, Graves, Hickman, and McCracken counties). Calloway and Marshall counties were targeted in Year 2.

Innovative Solutions to Problems

The biggest challenge encountered by the project was the overwhelming volume of referrals. To meet this demand, the project made several important staffing increases. The project increased its case management staff from 1.5 to 2.0 full-time case managers. The consortium management also agreed to fund a full office for the ROSE project and to hire an office coordinator.

The project also found innovative ways to improve access for people in wheelchairs and those who lacked transportation to medical appointments. The project manager negotiated discounted prices for the lumber needed to build wheelchair ramps at project sites. The project manager also negotiated a 50-percent discount from existing transportation companies, which allowed for transportation for more individuals needing services.

Results

The consortium originally anticipated reaching a total of 300 people (100 per project year). The program actually served more than 1,275 during the 3-year project. In addition to establishing the toll-free resource number, signing contracts with local transit agencies for transportation, and working with senior citizen centers to provide escort to the frail elderly in the first year of the grant, the project also developed gatekeeper training materials, purchased 150 emergency response units, and created an Alzheimer's caregiver support group in the region's largest county. In Year 2, the project expanded its target area to include two additional counties. It also expanded its case management staff and hired a full-time office coordinator. The resource center was developed to provide current information on self-help and preventive medicine. An Alzheimer's support group was started in Marshall County, and another 100 emergency response systems were purchased.

In the third year of the grant, the program continued to provide networking and services in the eight counties, and the emergency response system was provided to the Lourdes Senior Association using a fee scale, based on a person's financial situation. During the grant cycle, the emergency response system allowed 682 individuals and their families the assurance of senior care when the primary caregiver was unable to be there.

Potential for Replication

The ROSE project is an example of what can happen when organizations and agencies work together and share their resources for the good of the community. The program had powerful impact toward improving the quality of life and independence of frail-elderly and disabled residents, and preventing early nursing home placements. Transportation is likely to be the biggest challenge facing communities that implement this model. Volunteers and faith communities can be valuable resources in addressing this challenge.

After the Grant

The ROSE project will continue to offer the emergency response system at a discounted rate. In addition, case management services will be provided by referring individuals to area senior citizens centers, the Purchase Area Development District, local home health agencies, residential facilities, and other local organizations.

Population Served

In southeast Louisiana, teen pregnancy presents a serious health care and social dilemma, especially in three civil parishes. At the beginning of the Louisiana Learning About Pregnancy and STDs (LLAPS) project, the teen pregnancy rate in Tangipahoa Parish was 111 per 100,000 among African Americans and 41 per 100,000 among Caucasians. These rates are higher than the national rates of 83 per 100,000 for African Americans and 29 per 100,000 among Whites. Similarly, incidence rates for STDs in the region are among the highest in the United States. In Tangipahoa, the 1993 syphilis rate was 320 per 100,000—more than 11 times the national rate. Among African Americans, the rate was an alarming 603 per 100,000—more than 21 times the national rate. Washington and St. Helena parishes also experienced STD incidence rates that far exceeded national figures.

In southeast Louisiana's Tangipahoa, Washington, and St. Helena parishes, 38 percent of the population is African American. (St. Helena records an African American population of 51 percent.) The catchment area is one of the poorest regions in the State, with a median family income of $9,870. Families of color and female heads of household generally fall substantially below this figure. One-quarter of all families in the three parishes has been reported as living below the poverty level, a problem that is magnified by a lack of employment opportunities.

Services Offered

The LLAPS project was designed to address the health care status of rural teenagers in the three poor, rural parishes described above by providing peer-based health education, recruiting and training peer health educators in each parish, and conducting presentations on STD and teen pregnancy prevention to local civic groups, churches, and schools. The consortium members included the Louisiana State University Medical Center, Louisiana Reference Laboratories, Southern University Cooperative Extension Office, and Region IX Office of Public Health (Tangipahoa Parish). The medical center has worked with the Area Health Education Center (AHEC) of Southeast Louisiana since its inception in 1989. The medical school provided an obstetric/gynecologic resident who conducted community outreach and training, and helped ensure the accuracy of STD and teen pregnancy education and prevention programs. Reference

LOUISIANA

LOUISIANA LEARNING ABOUT PREGNANCY AND STDS
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Laboratories provided pregnancy, STD, and HIV diagnostic services. The Southern University Cooperative Extension Office provided training for peer leaders and opportunities for presenting the program to the parish communities. The regional Office of Public Health worked with the AHEC to provide effective, culturally competent health services for low-income families and to sponsor STD intervention clinics.

Innovative Solutions to Problems

The project developed a Web site that offered online chat rooms where people could gather to openly discuss STD and teen pregnancy issues. A physician and registered nurse were also available to answer questions. The Web site offered online quizzes that were graded by project staff, and corrected answers were sent back to the individual who took the test.

The project also recruited an African American pastor in Washington parish who was well-respected in the community and had many contacts. The pastor helped program staff gain access to the Bogalusa High School and various churches throughout the community. Without the pastor's assistance, it might have taken several months—or years—to reach these audiences.

Results

Since the beginning of the project, more than 25 health education training sessions were conducted each year. Since 1999, these sessions have enabled the program to reach more than 1,000 unduplicated individuals. More than 150 area teenagers received individual pregnancy and STD prevention counseling by community trainers.

Potential for Replication

The LLAPS program could be easily replicated in other communities, including rural communities of color. Teen pregnancy and STD transmission present serious challenges for many rural communities. The LLAPS curriculum requires minimal resources to implement, and the model itself has demonstrated success.

Although many agencies, organizations, and individuals dislike the evaluation process of paperwork, pre- and post-testing, and course evaluation, data collected through the LLAPS evaluation provided valuable insights into the knowledge deficits of many teens and the myths that exist regarding STD

transmission and teen-pregnancy. Establishing a strong evaluation component in the design of such programs is critical to understanding the population and enhancing project activities to increase effectiveness.

After the Grant

The LLAPS project is currently seeking new funding opportunities. However, regardless of whether new funding is secured, the program will continue. Many local churches and community organizations have agreed to conduct abstinence education programs for area teenagers.

Population Served

Five rural counties located in Michigan's lower peninsula cover an area more than twice the size of Rhode Island. This area is home to 82,319 residents. The region is one of the most economically disadvantaged areas in Michigan. A comprehensive assessment conducted in 1996 revealed that area youth had rates of tobacco use, alcohol use, and early sexual activity that exceeded state rates. In fact, rates of teen pregnancy were more than two times higher than statewide rates.

Services Offered

Partners in the Rural Prevention Network (RPN) included the lead agency, District Health Department No. 2, St. Joseph Health System, West Branch Regional Medical Center, the Alcona Health Center, and the Sterling Area Health Center. The two health centers are Federally funded rural clinics. Each RPN agency hired a full-time health educator to plan, implement, and evaluate the primary prevention programming aimed at reducing youth tobacco use, underage drinking, and teen pregnancy. The presidents and/or chief executive officers of each RPN agency met monthly to oversee fiscal and administrative matters. Health education staff, under the direction of the project coordinator from the District Health Department also met each month to coordinate activities. The primary prevention programs implemented by the project were school-based in nature and aimed at several age groups. Prevention programs placed strong emphasis on teen empowerment and using positive peer influence.

Innovative Solutions to Problems

All of the prevention activities supported by the project were based on nationally renowned prevention curricula or campaigns. Health education staff received training in the American Lung Association's "Teens Against Tobacco Use" national program, which trains high school students to deliver anti-tobacco presentations to fourth, fifth, and sixth graders. The project also expanded from 6 sessions to 10 sessions the "Taking Charge" curriculum, a skills and resiliency-based program that teaches youth to counter negative peer pressure, and incorporated alcohol, tobacco, and drug prevention messages. The pregnancy prevention program was based on the nationally evaluated

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"Postponing Sexual Involvement" curriculum series targeting young teens and was implemented at 11 middle schools in the 5-county area. In an effort to focus exclusively on the challenge of underage drinking, the RPN created a teen-based and peer-led coalition that included students, parents, school personnel, faith community leaders, law enforcement personnel, and RPN staff. The mission of the coalition, known as the Northeast Michigan Coalition to Reduce Underage Drinking, was to increase awareness of underage drinking throughout the region and to promote healthier alternatives for area youth. The coalition also coordinated teen rallies at various schools that featured "natural high" sessions, educational presentations, and anti-drinking campaign messages, such as those previously employed by organizations like Students Against Drunk Driving.

Results

Although changes in behavior cannot be documented in a 3-year time frame, the project evaluation indicates that the RPN succeeded in achieving its intended goals. The program yielded statistically positive changes in attitudes, skills, and beliefs, as demonstrated in pretest and posttest analyses. For example, the evaluation revealed a 52-percent improved accuracy in answering whether a girl can get pregnant if she has not yet had her first period. Teacher evaluation forms indicate that 90 percent of students learned something new about tobacco use. Although other tobacco-related evaluations did not reflect changes in attitudes or beliefs, consortium members recognized that increasing the knowledge of youth about tobacco is a precursor to changes in attitudes and beliefs—and perhaps one day, behavior. The youth-led alcohol prevention coalition received recognition as a model project that students involved in the coalition presented at a statewide conference.

Potential for Replication

Although communities are struggling with the issues of tobacco use, underage drinking, and premature parenthood. The efforts of the RPN and the model it implemented could work quite well in many types of communities. The main programmatic challenge that other communities may face in pregnancy prevention efforts is whether to teach abstinence only or abstinence-based curricula that permit the dissemination and sharing of information about safer sexual practices. Other communities should be aware that teaching anything about sex in a school system may lead to extensive scrutiny of educational materials and questions about the expertise of staff.

After the Grant

Additional funding has been received to support teen pregnancy programming, specifically the "Taking Charge" component. Local service organizations have provided funding for T-shirts, pamphlets, and other products to promote "Taking Charge." The underage drinking coalition received funding from a statewide nonprofit prevention group that supports underage drinking prevention activities.

The coalition plans to continue all prevention programs started under the outreach grant. The tobacco prevention initiative is the only program that has not obtained supplemental funding. However, school personnel can be trained to maintain tobacco prevention efforts.

MISSISSIPPI

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Population Served

Greene County is a small rural area located in southeastern Mississippi with approximately 10,200 residents. The nearest hospital is located in George County, approximately 25 miles south of Leakesville, the county seat. Before the establishment of the Community Medical Center of Greene County, an outreach-oriented primary care clinic, Greene County residents had limited access to medical care. There was only one clinic in the area, and it was staffed by a nurse practitioner and one retirement-age physician in poor health. The region included a large population of African American individuals and families—many of whom had limited income or lived at or below the poverty level. Incidence rates of heart disease and diabetes were high in recent years.

Services Offered

The purpose of the program was to increase access to primary care, laboratory, and radiology services for medically underserved individuals and families in Greene County. Prevention-oriented programs were designed to promote health, prevent disease, and reduce major risk factors for heart disease, diabetes, and cancer, including obesity, poor diet, hypertension, smoking, alcohol abuse, and other risk factors. The medical center was conveniently located to minimize barriers to transportation for health services.

Innovative Solutions to Problems

The project established seven ambitious goals for the project. They included (1) increased access to health care for individuals living in Greene County and the surrounding area, (2) a patient volume sufficient to allow the clinic to become self-sustaining, (3) provision of comprehensive primary and preventive care, regardless of socioeconomic status, (4) a library of patient teaching materials on the subjects of heart disease, diabetes, and cancer, (5) increased knowledge of self-care measures among medical center patients, (6) a comprehensive computer system to track referrals among network members and other health care providers (and to ensure timely and appropriate follow-up care), and (7) adding network partners as other service needs are identified by quarterly patient surveys.

Results

During the grant period, the medical center provided 14,400 units of primary patient care, 9,072 units of laboratory services, and 2,880 units of radiological services. In addition, 10,450 units of patient education were provided to residents of Greene County and the surrounding area.

The program served people of all ages. Approximately 29 percent of patients served were elderly persons aged 65 years and older, 25 percent were adults aged 20 to 64 years, 20 percent were adolescents aged 12 to 19 years, and 26 percent were children aged 0 to 11 years. A large percentage of patients were African Americans, and patient socioeconomic status ranged from severe poverty to average income levels. The gender of individuals served was almost equally divided between males and females.

Potential for Replication

The key to the medical center's success was the high degree of community cooperation. For example, pharmacists in the area have proved to be a valuable resource for patient education. The space for the medical center was provided by the Greene Rural Nursing Center, which turned out to be an ideal location for most individuals and families seeking primary and preventive care. At all times, the medical center placed strong emphasis on quality of care and ensuring that patients received high-quality, culturally competent care.

For other communities seeking to replicate this model, it is essential that they make the most of the planning process. Locating affordable office space can be a difficult process, but such a challenge can usually be resolved by gaining the support of community leaders. It is also critical that the project earn the support of participating providers because their involvement requires them to spend a great deal of time away from their primary practice sites. If communities take the time to plan their efforts appropriately and to gain broad-based support throughout the community, this service model could be easily replicated in other rural areas.

After the Grant

The Community Medical Center of Greene County continues to provide primary patient care and a range of patient education services. The project is currently exploring how to better use the Internet as a means to enhance its patient education efforts.

Population Served

The Ozark Tri-County Health Care Consortium's Rural Outreach Program was created to serve primarily low-income, rural residents of Barry, McDonald, and Newton counties in the extreme southwest corner of Missouri. In recent years, the number of Hispanic and migrant workers moving into the area has increased dramatically because of the rapid expansion of poultry manufacturing plants. Accessing primary health care services is a serious challenge—not just for low-income residents but also for the general population in the region. Barriers to primary health care included geographic isolation, low-income status, language, and limited local primary health care service delivery infrastructure.

Services Offered

The consortium originally comprised three programs whose operations were similar to those of limited liability corporations, each having its own mission, board of directors, and financial resources. The Ozark Tri-County Health Outreach Program Consortium Board of Directors included the administrators of the Barry, McDonald, and Newton county health departments, and the Executive Director of the Ozark Tri-County Health Care Consortium, Inc. Representatives from Crowder College and the Western Missouri Migrant Education Center actively participated in the Board's deliberations. The McDonald County Health Department served as the system's administrative agent until it was replaced by the Ozark Tri-County Health Care Consortium.

The organizations worked in close partnership to provide primary health care services to all individuals in the region, regardless of their ability to pay. The health departments in Barry and Newton counties provided space and support for a nurse practitioner to see patients at least 2 days per week. The Ozark Tri-County Health Care Consortium provided primary health care services 5 days a week in McDonald County and was staffed with two full-time physicians and two nurse practitioners who were scheduled 2 days per week. One of the physicians spoke Spanish and was a family practitioner who specialized in prenatal care. The other physician offered expertise in internal medicine.

MISSOURI

OZARK TRI-COUNTY HEALTH CARE RURAL OUTREACH PROGRAM
OZARK TRI-COUNTY HEALTH CARE CONSORTIUM, INC.
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Innovative Solutions to Problems

The project used two vans to transport patients to their respective clinics as needed. The vans were also utilized to provide health screenings and educational presentations at various senior centers, public schools, Head Start programs, migrant centers, and other community centers throughout the three-county area.

Results

The project delivered a full range of primary health care services to people throughout the region. In total, the program documented 9,214 encounters. Approximately 58 percent of those served were adults aged 20 to 64 years. The program also provided primary health care to 930 children aged 0 to 11 years, 371 adolescents aged 12 to 19 years, and 198 elderly persons aged 65 years and older. Nearly 60 percent of those who received services were female. In terms of ethnicity, 71 percent were Caucasian, and 24 percent were Hispanic. Some 43 percent of clients lacked health insurance, while 27 percent were enrolled in Medicaid, 10 percent were Medicare beneficiaries, and 20 percent had health insurance.

Potential for Replication

This model is ideally suited to rural communities with existing health care resources that can increase access and enhance effectiveness by working together. The model could be easily adapted to meet the unique needs of other rural communities.

After the Grant

The project will continue to serve the three-county area as part of the Ozark Tri-County Health Care Consortium, which will maintain clinics in the Barry and Newton county health departments in addition to its primary clinic in McDonald County. The Barry County Health Department outreach clinic is operating at maximum capacity but could be expanded when support staff are hired. The clinic in McDonald County moved to a new location in June 2000, doubling its service capacity. The clinic in Newton County, however, did not develop as planned, so its operations have been reduced to match patient needs in the county.

Population Served

Approximately 15,000 people live in Dent County. Its hills and rivers are part of the Ozark Mountains Plateau. About one-third of the county's residents live in Salem, the county seat. The county is scattered with farmers who raise livestock as a hobby or for supplemental income. Other residents work in the wood industry. The average wage earner makes approximately $8 to $9 per hour. The vast majority of residents are Caucasian, and many lack health insurance or are underinsured because many local small businesses do not provide health insurance to employees. Although there has been a concerted effort in recent years to enroll eligible children in the State's Children's Health Insurance Program, many area residents are medically underserved. Before to the outreach grant, after-hours and weekend primary care and medical services in the area were not available, causing many area residents to rely on local emergency rooms for care.

Services Offered

The primary goal of the Dent County Healthy Communities project in Missouri was to provide members of the community with improved access to health care at affordable and reasonable cost and to act as an information and referral resource base for health and social services available in Dent County. The first step toward achieving this goal was to develop a community-based coalition that would support a vertically integrated health network for rural residents in Dent County and ensure a continuum of services to promote healthy lifestyles, families, and babies

Innovative Solutions to Problems

Outreach grant funds were used to enhance Quickare, a non-emergency care facility expanded to provide after-hours services to Dent County residents, regardless of their ability to pay. The project also supported school-based social workers who provided education, training, and technical assistance to students, teachers, and school personnel. The project's dental and optical programs provided prevention and intervention services to non-Medicaid, uninsured individuals aged 18 years and younger. The "Helping Hands Crisis Line" eliminated duplication of services in the county by providing a single referral source for medical assistance, utilities, emergency shelter, local transportation, and

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food assistance. Other grant-funded activities included the development of a communitywide database piloted for the University of Missouri Outreach and Extension System, as well as posters and flyers describing health and social services available in the county.

Results

Since its creation, the after-hours clinic has seen more than 1,500 patients. An average of 10 patients were seen each weekday evening, and the average patient count on weekends was 13 per day. The expansion of the Quickare clinic hours greatly increased the availability of physician care after working hours and on weekends. The school-based social workers conducted a Lice Education Assistance Program that began in fall 1998. Since that time, more than 60 students and their families have participated in the program. The school-based social workers also assisted all local school systems to conduct lice checks. Nearly 300 youth aged 18 years and younger received referrals to dental services, and 56 youth were referred to optical services. The Helping Hands Crisis Line received more than 350 calls during the grant cycle and provided more than $25,000 in assistance to local residents. (This figure does not include food donations.) It is important to note that many of those who received services through the project would not have received those services without the program's assistance.

Potential for Replication

Communities are already replicating this model. Representatives from Dent County Healthy Communities, the University of Missouri Outreach and Extension, and the State health department have held numerous training academies for community organizations implementing similar types of projects. Consortium members have also provided technical assistance to other rural programs.

In retrospect, consortium members have indicated that the program may have tried to implement too many new initiatives at the same time. Early in the project, staff found themselves overwhelmed. To prevent this from happening in

other communities, organizations may want to narrow their focus on major priorities early in the implementation process and consider expansion once core activities are up and running.

After the Grant

The Quickare clinic is self-sustaining and will remain open under the direction of the Big Springs Medical Association. Local school systems are considering how to continue support for school-based social workers and are actively seeking funding opportunities. The Helping Hands Crisis Line has established a strong and vibrant relationship with the local ministerial alliance, and they are exploring additional sources of funding. All other programs will continue based on the need for services and available funding.

MONTANA

HEALTH AND OPTIMUM PERFORMANCE FOR EVERYONE (HOPE) PROGRAM FOR PEOPLE WITH DISABILITIES IN WESTERN MONTANA

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Population Served

The Health and Optimum Performance for Everyone (HOPE) program was created to improve the health status of people with physical disabilities by helping them adopt a healthier lifestyle and reducing the incidence of secondary conditions (e.g., urinary tract infections). The program targeted adults with physical limitations living in Missoula County, Montana. People with disabilities who live in rural areas are at particular risk for social isolation or being homebound. When this occurs, it is common for them to experience feelings of hopelessness and even despair about their ability to lead a meaningful life.

Like the general population, people with physical disabilities benefit substantially from health promotion and fitness programs. In addition to the benefits that have been widely documented for the general population, people who have disabilities caused by an injury or disease can reduce their risk for a variety of secondary conditions by adopting healthier behaviors.

Services Offered

Many clients entered the program with a range of disabling impairments, including spinal cord injuries, multiple sclerosis, cerebral palsy, traumatic brain injuries, and arthritis. The HOPE program provided two phases of interventions. The first phase focused on identifying, recruiting, and preparing participants for the program. The second phase focused on encouraging lifestyle change through a group-oriented intervention that used materials from the Living Well with a Disability program. Specific services provided through the community-based wellness program included group and individual counseling, regular physical activity, one-on-one and group nutrition consults, and group and individual chronic pain management consults.

Innovative Solutions to Problems

The original design of the HOPE program was built around a 4-month wellness program using public health department services to recruit participants and local YMCA services to address long-term maintenance and behavioral goals. The consortium included the local center for independent living (a federally funded information and referral program for people with disabilities), the local aging agency, and the State's Medicaid

waiver office. These agencies were to provide primary access to the target population of adults with physical limitations. Once individuals were identified by these agencies, a public health nurse went to their homes to assess readiness for the program and to address barriers that would compromise their ability to engage in the program. Following this preparation process, eligible clients participated in a 4-month treatment protocol that included 8 psychoeducational group sessions and up to 24 supervised exercise sessions. Upon completing the 4-month program, clients were supposed to continue their physical activity regimen at the local YMCA for 6 months.

During the first 18 months of the project, three serious challenges were encountered. First, the building where the program was housed had to be demolished. Alternative housing provided by St. Patrick Hospital was located on the edge of town in an area that was difficult for people with disabilities to access. Second, the number of clients referred to the program fell far short of the consortium's projections. And third, whereas 85 percent of participants completed 3 months of physical activity, only 15 percent were successfully transitioned to the YMCA for 6 months of follow-up. To resolve these challenges, the consortium established a 2,000-square-foot community wellness center in the second year of the project. With the development of the freestanding clinic, which could support the long-term physical activity goals of clients, the program then revamped its recruitment strategy. To this point, the program had relied on passive recruitment efforts, such as newsletter articles, letters, newspaper articles, and meetings, which had been ineffective. Instead, the project established relationships with local medical and rehabilitation providers and encouraged them to refer clients to the program. This approach was significantly more successful. Project staff began to notice major improvements in the percentage of clients maintaining long-term behavior changes.

Results

Some 233 clients with physical limitations were served during the course of the project. About half of these individuals participated in regular physical activity twice a week for an average of 23 weeks. Most clients were Caucasian and averaged 62 years of age. Participants reported a 28-percent decrease in physical limitations due to secondary conditions and a 38-percent increase in the ability to carry out daily activities independently. These outcomes were mediated by substantial increases in good dietary and physical activity practices. As healthy behaviors improved, secondary conditions declined.

In year 2 of the program, the project helped 100 individuals develop regular physical activity programs and collected data on exercise-related indicators. These individuals averaged 23 exercise sessions. Their level of cardiovascular work increased by 59.1 percent, lower body strength increased by 152 percent, and upper body strength increased by 104 percent.

Potential for Replication

The New Directions facility (the freestanding physical activity clinic) could be easily replicated in any rural hospital or agency with even a modest rehabilitation program, a physical therapist, and at least some exercise training equipment. However, for the project to succeed, organizers will need to secure at least minimal funding. Private and public insurance payments typically cover only medical models of acute illness. For example, they do not cover the services of a registered dietitian, nor do they reimburse for physical therapies, even when provided in a group setting. People with chronic illnesses or permanent injuries require a different funding mechanism, but these needs are not yet reflected in the health care policy arena.

Programs must be adequately prepared to provide a significant amount of support and resources to clients. People with disabilities often experience a profound sense of hopelessness and discouragement. Helping them change behaviors and adopt a healthier lifestyle takes time, energy, and support. Other communities must be prepared to make such an investment.

After the Grant

The HOPE program will continue to provide services by collecting third-party reimbursements, when possible, and by securing additional grant funding. The program also hopes to expand its efforts in the areas of health and disability research.

NEBRASKA

Population Served

The original service area for the Children's Outreach Program consisted of 11 rural counties located in the western Nebraska panhandle. However, two more counties were eventually added to the target service area. A total of 91,000 people live in the area, which covers 100 miles by 120 miles. The project grew out of the experience of one hospital which found that home visits greatly reduced the number of inappropriate emergency room episodes.

Services Offered

The consortium consists of nine hospitals and two public health/social service agencies. One hospital serves as the grantee and fiscal agent. Other consortium members participate in setting program guidelines, solving problems, planning services, and evaluating the project.

The Children's Outreach Program conducted home visits to families with newborns within a few days after the mother's return home. Additional home visits were made as needed. The most common issues dealt with during the home visits included breastfeeding concerns, jaundice, infant weight gain, and the mother's knowledge of infant care. Other issues that emerge from time to time included post-partum depression, infection, bonding, and safety. During home visits, nurses show parents how to use car seats properly, how to prevent Sudden Infant Death Syndrome, and discuss home safety. The program also provided a means for enrolling area infants and children in the State's Children's Health Insurance Program, helping teen mothers access General Educational Development and school programs, and linking families to the Women, Infants, and Children Program, immunization programs, and other health and social service agencies.

The program also conducted home visits for children aged 0 to 5. Some families need extensive training in infant care, basic sanitation, preventing future unplanned pregnancies, and finding community resources to provide for the child. Some families are visited on a weekly basis. Others are visited once a month.

Home visitation staff from hospitals and agencies participating in the consortium received training on conducting health assessments, breastfeeding, child abuse and neglect

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reporting, working with teen parents, brain development in infants, early intervention, alcohol and other drug use, and culturally competent health and social services delivery to American Indians.

Innovative Solutions to Problems

The original plan for recruiting families was to wait for families to request a visit, but this approach didn't work. Therefore, the consortium decided to provide information about the program to every family at the time their child was born. Families were asked to sign a form giving consent for the visit and permitting program staff to send pertinent information to another hospital or home health agency if the family lived in another county. This approach was significantly more successful, and 76 percent of all babies born in the service area have received at least one home visit. On one occasion during a home visit, shortly after the program started, an infant was referred to a physician for rapid breathing. The baby was soon diagnosed with cancer, and when only 6 days old, had surgery. The surgeon indicated that early diagnosis dramatically increased the infant's chances of survival. This experience inspired the consortium members to believe that every family could benefit from the home visitation program—not just families with problems or those having their first baby.

Results

Between October 1997 and April 2000, program staff conducted 2,769 home visits for newborns and 2,108 home visits for children aged 0 to 5. As a result of the outreach grant, more than 2,100 area families were served, and 70 individuals received training on how to conduct home visits.

Potential for Replication

The project yielded several lessons that may be relevant to rural communities seeking to establish a similar program in their area. Recruiting parents at the hospital of delivery is essential to success, simply because many new parents either are reluctant to ask for help or think they don't need it. Only a small number of families will probably require extensive and ongoing home visits, but communities should nonetheless be prepared to meet the needs of these families in a nonjudgmental and nonstigmatizing way. This model also demonstrates that health and social services can be delivered jointly to better address each family's unique needs.

In retrospect, members of the consortium indicate that hiring an outside coordinator—someone not affiliated with any of the member organizations—was a wise decision. This approach eliminated concerns over territory, bias, and inequity among members of the consortium.

After the Grant

The network is committed to continuing the Children's Outreach Program. The hospitals have agreed to provide funding for one home visit per newborn. Funding for additional visits will be provided through Medicaid, insurance, and other grant resources.

NEBRASKA

HISPANIC ADOLESCENT ACCESS PROJECT NETWORK (HAAPN)

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Population Served

In the past decade, Nebraska has experienced tremendous growth in the Hispanic/Latino population. The 1997 U.S. Census estimates document a 32-percent increase, primarily due to migration of Hispanic/Latino families from border towns in Texas, California, and Mexico. Most come to rural central Nebraska to work in meat processing and packing plants in the area. Although communities welcomed the prospect of improving the local economy by expanding the meat processing and packing industry, most were not prepared for some of the ensuing results—the lack of affordable housing, inadequate schools and personnel, language barriers, and the inability to access health care services. Hispanic family incomes typically are at or below the poverty level, and many adolescents have limited or no English skills.

The five central Nebraska counties targeted by the Hispanic Adolescent Access Project Network (HAAPN) have rates of teen pregnancy, low birthweight, and insufficient access to prenatal care that are higher than State and national averages. Fertility rates for Hispanic females aged 10 to 19 are higher than those of their Caucasian counterparts. Though they represent only 3 percent of the population in these counties, they account for 18 percent of live births. Early childbearing has put an increased burden on the health and human service system and increased costs for everyone.

Services Offered

The HAAPN was created to reduce teen pregnancies among Hispanic adolescents living in the service area. The project was also designed to increase access to health care, including mental health services, for Hispanic adolescents who are pregnant, parenting, lack insurance, or are inadequately insured. The target counties of Adams, Colfax, Dawson, Hall, and Platte developed and implemented a variety of community education programs intended to promote delayed sexual activity, and provide information concerning pregnancy prevention, single adolescent parenting, and sexually transmitted diseases. The consortium,

comprising 12 members, established formal linkages to increase access to prenatal and preventive health care services for Hispanic adolescents and their children.

Local hospitals, nonprofit organizations, schools, mental health providers, resource centers, churches, businesses, and industries were represented in the consortium. The Multicultural Human Development Corporation served as the lead agency, providing administrative management and project coordination, as well as bilingual insurance education, translation services, and cultural diversity training. St. Francis Medical Center, Mary Lanning Memorial Hospital, Columbus Community Hospital, and the Northeast Diagnostic Resource Center provided pregnancy prevention education, prenatal care, postnatal and parenting education, referrals, follow-up care, and direct services. Each network member planned activities and services that were most responsive to their community's unique needs.

Innovative Solutions to Problems

Network members worked with local employers to promote increased access to health insurance. For example, bilingual personnel provided insurance education to employees at meat processing and packing plants to increase their understanding of the need for and utilization of family health insurance. The Student Wellness Center, Center for Family Health, local schools, the Women, Infants, and Children program, and local health departments played a major role in increasing enrollment of uninsured children in Nebraska's Children's Health Insurance Program. The network also joined forces with Creighton University to establish the Parish Nursing Program in Grand Island. The program offers screening, assessment, referrals, and health education to many of the area's Hispanic families.

Results

As a result of the outreach grant, existing programs and services in rural central Nebraska are now more accessible to Hispanic adolescents and their families. More than 4,300 area students, adolescents, and parents received abstinence education, and more than 300 people received prenatal care and education. Some 105 individuals participated in Spanish-language Lamaze or breastfeeding classes, 280 people benefited from follow-up and home visitation services, and 58 instructors received abstinence training. The employee insurance education program reached nearly 1,750 workers. Because of incomplete record-keeping early in the project, these numbers significantly under-represent the total number of adolescents and families served by the

program. The network also offered 5 cultural diversity training sessions in 4 central Nebraska communities, with a total of 80 educators and health care professionals attending the trainings.

Potential for Replication

Bicultural and bilingual health care professionals, paraprofessionals, and educators were critical ingredients in the program's success. While there continues to be a tremendous need for services, especially mental health services, among the area's Hispanic adolescents, these personnel played an important role in promoting culturally competent prevention, health promotion, and medical services. Communities with a large ethnic population, committed to providing health care services for all, should consider these factors in replicating this model. Establishing linkages between area churches, schools, health care providers, businesses, and human service agencies helps to maximize limited resources and to reach a larger number of individuals and families.

After the Grant

Area hospitals will continue to provide the health care safety net for Hispanic families in the area. Activities and services created as a result of the outreach grant have been incorporated into the public health infrastructure of these hospitals and will continue to be offered to area families. Local churches and the Nebraska Abstinence Program are supporting ongoing abstinence education. In addition, the Platte/Colfax County District Health Department has initiated a $5 service fee so it can continue to provide clinical care for low-income and indigent individuals.

NEBRASKA

RURAL HEALTH OUTREACH
ELDER CARE PROJECT
CENTRAL NEBRASKA
COMMUNITY SERVICES
LOUP CITY, NE

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Population Served

In March 1997, Central Nebraska Community Services staff and elderly care providers in six target counties in Nebraska met to discuss the area's top priorities for aging services. The top five identified priorities were (1) transportation to services and activities, (2) creating a qualified work force for elder care services, (3) wellness and prevention services, (4) training and education for professionals and paraprofessionals, and (5) network development activities to integrate elder care services, share resources, and advocate for policy development and public knowledge about aging issues and needs.

The Elder Care Project at Central Nebraska Community Services targeted adults aged 65 and older living in Boyd, Brown, Cherry, Holt, Keya Paha, and Rock counties who had self-care, mobility, and transportation limitations. The goal of the program was to enable older adults to remain independent in their own homes and prevent premature institutionalization and repetitive hospitalizations. Growing old in one's own home rather than a nursing home is the preferred choice of older adults.

Services Offered

The consortium consisted of an advisory network of approximately 11 individuals and 4 partners from local organizations. The advisory network was responsible for helping to build strategic partnerships between public and private service providers. It also planned and implemented services which enhance resources and prevent duplication, and promoted shared training and continuing education opportunities. The advisory board was composed of representatives from the veterans administration, housing authority, health and human services, former and current county commissioners, a high school teacher, a retired minister, and members of the community.

Services provided by the project included lifeline, chore and personal care services, home maintenance and yard work, nutritional supplements, mental health evaluations and ongoing therapy, transportation to health and social service appointments and social outings, home visitation, service coordination, friendly visitation, and home safety products.

Innovative Solutions to Problems

The visitation program was one of the most popular services offered by the program. Many older persons in the area are isolated from the community in which they live or are tired of seeing the same people they have seen for several years. For many clients, a visit from their home visitor brightened their day. It also provided a means to engage seniors in health care services.

Results

More than 400 people benefited from the lifeline program, more than 850 residents received chore and personal care services, and more than 300 received nutritional supplements. Some 51 residents received mental health services, 99 people received transportation services, and clients received a total of 129 home safety products. The program also recorded 3,514 home visitation contacts. By the end of the grant cycle, the project had a volunteer base of 50 persons qualified to provide transportation services to elderly residents in the target area.

Potential for Replication

Like the Rural Health Outreach Elder Care Project, other communities will find it difficult to meet the demand for aging services. For a program targeting elderly individuals to succeed, the full range of community resources must be leveraged toward creating a comprehensive network of aging services. Seniors require a great deal of support in order to live independently and sustain a high quality of life.

In addition, given the dearth of aging resources available in most communities, other organizations and consortia should begin to plan for program continuity from the day it starts. Funding for elder care services is difficult to find.

After the Grant

The consortium is looking for funding to sustain the program and is currently exploring the possibility of encouraging the Nebraska Legislature to expand the model statewide and make it State-supported. Given the interest the program has generated across the State and with local senators, this is potentially a viable option.

Population Served

Call-Care's telephone triage service encompassed 15 rural counties in southeast Nebraska. The area, which covers 7,873 square miles, consists of small cities, rural villages, and a large farming community. The total population of the 15-county area is 161,282. Included in that number is a small number of African American, Hispanic, Asian, and Native American individuals. The economy is predominantly supported by farming and agricultural businesses.

Services Offered

The primary objective of the Community Access to Coordinated Healthcare (CATCH) project was to establish a public health nurse-based, toll-free telephone triage service that would be available to all rural residents in southeast Nebraska 24 hours a day, 7 days a week. Public health nurses provided health information and education, referrals, case management, and other resources to help callers access a reliable medical home. Demographic, geographic, and epidemiologic information was collected from callers and entered into a project database. Although the project focused its efforts on addressing the needs of the underserved, the service was available to everyone in southeast Nebraska.

The consortium provided a public health nurse to assist callers during the day. To ensure that callers always heard a "live voice" when they called the service, the consortium contracted with a small rural hospital to provide after-hours triage service—at a discounted hourly rate. Triage summaries were faxed to the caller's primary care physician and/or hospital. A public health nurse followed up with the client within 48 hours to learn whether additional services, education, or referrals were needed. AT&T's language line was used to address language barriers.

The consortium originally consisted of six area public health departments, one community action agency, the Southeast Rural Physician Alliance (a physician network), and the Blue River Valley Health Care Network (a hospital network). However, the hospital network eventually stopped participating in the consortium. All health care providers and health and human service agencies were eligible for CATCH membership.

NEBRASKA

CALL-CARE
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Innovative Solutions to Problems

The biggest challenge experienced by the program involved educating the general public to use Call-Care. The call volume projected in the grant application was never achieved despite aggressive marketing practices, such as news releases, public service announcements and newspaper ads, brochures and posters displayed in highly visible public places, and presentations to local organizations and the medical community. CATCH finally found three marketing tools that yielded success—refrigerator magnets, posters with tear-off pads, and small stickers that fit on telephones. All of these marketing products prominently displayed Call-Care's toll-free number. CATCH also produced newsletters targeting area physicians to update them on program activities, and CATCH public health nurses visited medical offices on a quarterly basis to get feedback from providers and office staff.

Because of these and other efforts, triage calls in 2000 increased by 40 percent every month. Several users of the service are repeat callers who have expressed satisfaction with the service and use it regularly to obtain referrals to providers.

Results

During the reporting period, the telephone triage service provided 1,629 consultations. A total of 18,663 client records were registered in the project database. More than 13,000 Medicaid clients were served. The average age of male callers was 37 years, and the average age of female callers was 26 years.

Potential for Replication

Random satisfaction surveys showed that 85 percent of clients thought that Call-Care was very helpful, and 98 percent said they would use the service again. These numbers indicate that the Call-Care model could be successfully replicated in other rural areas.

One of the most important lessons learned by the project was that marketing a new program requires persistence. Another important lesson was that it is critical to communicate with area providers on a regular basis.

After the Grant

CATCH secured an annual renewable contract with the Nebraska Department of Health and Human Services that partially funds the public health nurses who staff the triage service.

Population Served

Las Promotoras de Salud Consortium service area covers Rio Arriba County in northern New Mexico. It contains nearly 6,000 square miles and an estimated population of more than 36,000 people. Unlike many community health centers, *Las Promotoras* covers a particularly large service area with an extremely low population density of 6.2 persons per square mile—many of whom are of American Indian and Mexican heritage. About one-quarter of all residents live in urban areas. The rest live in rural settings. Harsh weather conditions—particularly during the winter—often prohibit travel by clinic staff and patients. Hazardous road conditions and severely cold temperatures contribute to access limitations and increase program operating costs.

Rio Arriba County ranks among the top 10 counties in New Mexico with the highest percentage of families living below the poverty level (nearly 37 percent). The county also ranks last in the State in per capita income ($10,332 per year).

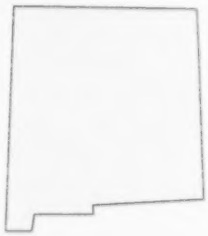
Services Offered

Las Promotoras de Salud describes individuals who take responsibility for promoting health, well-being, skills, and knowledge to the community in culturally responsive and respectful ways. The most important qualification one must possess to serve as a *promotora* is to be someone whom others know, trust, and respect. Their primary function is to educate others about healthier behaviors and the resources available in the community.

The primary purpose of the project was to provide a culturally responsive health promotion and disease prevention program that also increased health care access to rural communities in northern New Mexico.

The consortium included eight members. The lead organization, Hands Across Cultures, Corp., provided technical assistance to other consortium members and oversight of the *promotoras*. Health Centers of Northern New Mexico provided direct medical care (including screenings and assessments), outreach, and coordination with existing managed care systems. The National Multicultural Association provided technical assistance to other consortium members, recruited and trained

NEW MEXICO



LAS PROMOTORAS DE SALUD
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promotoras, and wrote and focus-tested information materials. Las Clinicas del Norte, a network of rural primary health care centers, provided direct medical care and a range of health promotion and disease prevention services. The Area Health Education Center provides training for *promotoras* and consortium health care providers.

Other community organizations also were involved in the project. For example, the Ministerial Alliance helped recruit *promotoras* from local faith communities and integrated health-positive messages into sermons and religious life. Highlands University provided scientific oversight and guidance and led the evaluation effort

Innovative Solutions to Problems

Originally, the project director was tasked with the responsibility of recruiting *promotoras*. However, in the project's early days, it was difficult to find an individual who was willing to make a commitment to the project. To overcome this challenge, other consortium members agreed to participate in *promotora* recruitment efforts. At first, they were uncomfortable with their new role, but they persevered because they were committed to the project's success.

Results

Las Promotoras de Salud was a successful endeavor for many reasons. During the reporting period, 180 individuals received blood sugar testing and monitoring services, another 180 persons received foot checks, and 500 people received diabetes screenings. Nearly 40 percent of those served were people aged 65 and older, and approximately 60 percent of all clients were female.

Another ingredient in the program's success was that consortium members not only assumed responsibility for certain tasks and for providing certain services, they also served as a "management team" for the project. A spirit of cooperation, coupled with meaningful and effective communication, played an important role in keeping the project on track and sustaining the consortium.

One of the most important lessons learned through the project is that *promotoras* and evaluators need a common "language" with which they can communicate. At first, the *promotoras* did not adequately understand the purpose of the evaluation and why they had to document their activities. Eventually, however, they realized that documentation is necessary to demonstrate their success as health educators and resources, as well as the success of the project.

Potential for Replication

This model can be easily adapted in other communities in which culture plays a powerful role in individual health attitudes and behaviors. In order to motivate individuals to modify behaviors, seek treatment, or adhere to a treatment regimen—and ultimately increase access to care—it is critical that health education and promotion efforts be culturally responsive and delivered by culturally responsive individuals.

After the Grant

The consortium members worked together to develop a strategic resource development plan to maintain and expand program activities beyond the grant cycle. In addition, the program had originally planned to recruit youth to serve as *promotoras* upon completion of a 4-week training program. However, it was unable to implement the program during the grant period. The consortium hopes to implement the program in the near future.

Promotoras are currently participating in the *"Salud para su Corazón"* (Healthy Heart) project funded through the National Council of La Raza. The program focuses on heart disease prevention and education.

Population Served

Hidalgo County is located in the southwest corner of New Mexico. It is a frontier county with a population of 6,354 in 1997 and a population density of 1.8 people per square mile. The county is bordered by Mexico to the south and Arizona to the west, and is one of the most isolated counties in the State. Much of the county is only accessible via dirt roads. Half of the county's population is of Hispanic origin, while the other half is Caucasian. About 12 percent of the population is aged 65 and older—20 percent higher than the State average. More than 20 percent of the county's residents live below the poverty level, and 47 percent of these individuals live below twice the poverty level, making Hidalgo County one of the poorest counties in the State. When the Phelps Dodge Copper Corporation closed its smelter operation in Playas in September 1999, unemployment in the county rose from a 5.8 percent 5-year average to 20 percent—overnight.

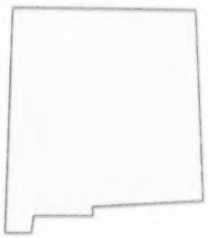
Half of the county's residents live in Lordsburg, which is 160 miles from Tucson, 300 miles from Albuquerque, and 120 miles from Las Cruces—the nearest metropolitan areas. Given the distance from these cities, accessing health care services is a formidable challenge for Hidalgo County residents. Dental services have never been available in the county, and prior to the outreach grant, basic primary health care services had not been available in more than 10 years.

Services Offered

The primary goals of the Hidalgo County Health Consortium were to expand the delivery of primary care services, develop support services for providers, implement community strategic planning processes, and establish new health care services throughout the community. Secondary goals of the program included developing telemedicine and teleradiology services; supporting technical assistance activities to promote program development; developing outreach, prenatal, and dental services; and sponsoring at least one health fair per year.

The Hidalgo County Health Consortium consists of eight members. The lead agency, Hidalgo Medical Services, is the primary medical, dental, and outreach provider. The Border Area Mental Health Program offers mental health services, as well as

NEW MEXICO



DEVELOPMENT OF BASIC HEALTH SERVICES IN HIDALGO COUNTY

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drug and alcohol prevention services. The University of New Mexico offers technical assistance, community development, telemedicine, peer review, locum tenens services, and health professions students to provide staff support. The other consortium members—Animas Schools, the Healthier and Drug-Free Schools Program, the Southern Area Health Education Center, the New Mexico Department of Health, and Lordsburg Public Schools—provide a range of service coordination, planning, community development, and nursing services.

Innovative Solutions to Problems

One of the most innovative features of the program was the role of the University of New Mexico in supplementing the range of services available to clients and increasing the quality of care. For example, the University's physician support activities included recruiting providers, overseeing staff, and making the results of teleradiology services available overnight. In addition, the University provided dental faculty who were flown to Lordsburg each week to supervise the clinics, assist in recruiting staff, and provide training.

Results

Since receiving the outreach grant in October 1997, the program has enjoyed substantial growth. In its first year, the program provided primary care services to 2,008 users who registered 4,812 encounters. While final data are not available, it is projected that, in 2000, the program will document approximately 7,750 encounters with 2,800 clients. In addition, between July 1998 and June 1999, two *promotoras* (who provide health education and promotion services) recorded 4,212 contacts, including one-on-one encounters, peer groups, home visits, referrals, family support services, and other types of services.

In the summer of 1998, Hidalgo Medical Services was awarded a contract by the New Mexico Department of Health to provide Women, Infants, and Children (WIC) services in Hidalgo County. At the time, an average of 200 clients per month were using WIC services. Since then, the client base has increased to approximately 300 clients per month. Similarly, in the summer of 1998, Hidalgo Medical Services began providing Family First services—a case management program for Medicaid-eligible children and pregnant women. Since its inception, the program has served more than 100 clients.

The program also has experienced substantial increases in the demand for other types of services. For example, in 1998, the program logged 997 dental service encounters. In 2000, it is projected that the program will provide approximately 3,540 units of dental services to an estimated 2,500 clients. Teleradiology services are now available to clients, with results available the next

day. Other new services made possible by the outreach grant include school physicals and free or low-cost prescription drugs for low-income clients. In each year of the grant, the consortium members collaborated in sponsoring at least one health fair. In the final year of the grant, approximately 350 people participated in the fair.

Potential for Replication

One major reason for the consortium's success is the amount of planning that took place before the outreach grant application was submitted to the Office of Rural Health Policy. The consortium members conducted needs assessments, prioritized service areas, and established positive working relationships with local government and statewide resources, such as the New Mexico Office of Rural Health and the University of New Mexico Office of Rural Outreach. All of these efforts contributed to a unified vision for program implementation Others who are considering implementing a similar model should take time to plan their efforts accordingly. Likewise, organizations seeking to establish such a model may need to increase their knowledge of clinical policies and procedures, and specifications for electronic information systems to manage patient records, finance, and billing.

After the Grant

The new services established as a result of the outreach grant are now an integral part of service delivery in Hidalgo County. If patient visit projections are realistic, the program should be able to continue all primary care, training, and outreach services that were offered during the grant cycle. Consortium services will be funded in part by Hidalgo Medical Services, the Southern Area Health Education Center, and a Kellogg grant. Other consortium members will continue to provide in-kind support in the form of service delivery and support staff. In 2001, Hidalgo Medical Services, Hidalgo County government, the City of Lordsburg, and other county organizations will begin construction of a new 18,000-square-foot medical, dental, and public health facility adjacent to the existing building.

NEW YORK

ORAL HEALTH OUTREACH IN AN UNDERSERVED RURAL AREA OF WESTERN NEW YORK

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Population Served

According to national and New York statistics, the average number of decayed teeth increases as household income decreases. Poor oral health leads to poor nutrition and other health problems. Many dentists, however, do not accept those who may need care the most because of inadequate health coverage, insufficient income, or physical condition. This is particularly true in two rural counties in southwestern New York. In Allegany County, the second poorest county in the State, and Cattaraugus County, the seventh poorest county in New York, 30 percent of the population are low-income households. Most of Allegany County has a ratio of 1 dentist to every 12,403 low-income people. In Cattaraugus County, the ratio varies from 1 dentist to every 5,226 people to 1 dentist for 61,535 low-income people, and 70 percent of the county's residents receive water from private wells or from nonfluoridated municipal supplies. The lack of dental services for Medicaid recipients, low-income persons, and other special populations (children, the developmentally disabled, elders, and the Amish) is further complicated by common rural barriers—geography and weather, absence of public transportation, a larger percentage of families without insurance than in urban areas, and a general lack of awareness of good dental health.

Services Offered

To improve oral health throughout this region, three hospitals in the Southern Tier Health Care System—Cuba Memorial Hospital, Salamanca Health Care Complex, and Tri-County Memorial Hospital—joined forces to design a regionally coordinated program to provide dental services for patients in need. Each member of the consortium brought different skills and resources to the project. For example, Tri-County Memorial Hospital, a 65-bed acute care facility, offered the services of its chief dentist, who served as the project director. It also provided outreach preventive care, school-based oral health education for low-income children, and training opportunities for staff at the new facilities. In addition to establishing a clinic in Allegany County, Cuba Memorial Hospital participated in outreach and education efforts. Grant funding covered a portion of staff salary expenses, marketing costs, telephone service, supplies, and clinic equipment.

PROJECT 31—ORAL HEALTH OUTREACH

The main goal of the project was to build a comprehensive network of oral health providers in southern New York so that medical and geographic barriers to primary and preventive dental health services could be eliminated. The project was also designed to provide a range of education and prevention services, community planning, dental rural residency development, and support for the State's Children's Health Insurance Program (CHIP). In fact, the Southern Tier Health Care System now serves as a site for CHIP enrollment.

Innovative Solutions to Problems

The Salamanca Health Care Complex, which was expected to house one of the two dental clinic sites, closed in 1998 and was no longer able to participate in the consortium. As a result, Tri-County Memorial Hospital, which housed the other dental clinic, agreed to establish a clinic in the city of Salamanca.

The consortium members strongly believed that the project should include and represent all segments of the community—from the very beginning. To facilitate this process, the Cattaraugus County Health Department sponsored a community-planning forum to identify community needs, priorities, and solutions and to solicit the participation of other organizations interested in working with the consortium. The Dental Health Committee and its 4 subcommittees—all of which evolved from the forum—now include 37 members from 4 counties. Among the members are representatives from local schools, the State University of New York at Buffalo Dental School, county departments of health and social services, human service and health providers, consumers, regional networks, local governments, and dental societies. Because of this broad-based community involvement, it was possible for responsibilities to be shared and for the project to exceed its original goals. At first, private-practice dentists in the region opposed the development of the clinics, fearing that they would lose clients. However, after participating in the forum and in the decisionmaking process, many of these dentists now work at the Cuba site. A spirit of cooperation and collaboration replaced fears of competition.

One innovative practice employed by the project was offering dental screenings in schools with high numbers of low-income children. School nurses obtained written permission from parents and guardians allowing a dental hygienist to screen children at school. Children who needed oral services were referred either to their private provider or to the closest clinic.

Results

Although final data are not yet available, it is estimated that the Cuba Memorial Hospital dental clinic provided more than 3,100 units of dental services to approximately 1,400 users. It is also projected that the Salamanca

site will provide approximately 4,222 units of service to some 1,689 users. In the first 3 months of operation at the Cuba site, 54 percent of clients were Medicaid recipients, 25 percent were uninsured, 2 percent were covered by the State's Child Health Plus program, 1 percent were covered through the Federal Hill-Burton Act, and 18 percent had private insurance. Five percent of all patients served were aged 65 and older. These figures provide at least preliminary confirmation that the program was successfully reaching its target population.

It is also estimated that approximately 52,000 viewers saw the program's television ads. In addition, 150 families visited the program's booth at the 2000 Dental Fair, and 1,839 children received oral health education at school presentations.

Potential for Replication

What made this program unique was its strict focus on oral health services and education. While this model could be replicated elsewhere, it is critical that program planners involve a broad range of community organizations and individuals in designing and implementing the project, including local dentists. It is also important to note that a network-development model could be effective in addressing a range of other public health challenges facing rural communities.

After the Grant

Given the fact that the program experienced several delays in constructing and establishing additional dental clinics, the consortium received an extension so that grant funds could be used past the grant cycle. It is expected that insurance revenues will enable the clinics to stay open. Meanwhile, the consortium is seeking funding from other sources so that program services can be enhanced and expanded.

NORTH DAKOTA

COMMUNITY EMERGENCY MEDICAL PROGRAM
ASHLEY MEDICAL CENTER
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Population Served

The Community Emergency Medical Program in Ashley, North Dakota, targeted a service area that included most of McIntosh County's 3,000 residents and residents of the neighboring counties of Dickey, Emmons, and McPherson. The Ashley Ambulance Service was having trouble recruiting and training emergency medical services (EMS) personnel, and discontinuing emergency services to the community was discussed. The Ashley Fire Department, which provided extraction services to the area, had received "Jaws of Life" equipment through a grant from the North Dakota Department of Health. However, the grant stipulated that the fire department was required to become "Heavy Rescue" certified in order to keep the equipment.

Considering that the Ashley Ambulance Service was on the brink of disaster and the Ashley Fire Department was on the verge of losing equipment that was vitally needed in outlying areas, it was necessary for all emergency care providers to develop a training and recruitment program for volunteer recruits and to enhance the skills of existing personnel.

Services Offered

The grant made it possible for the consortium to provide training to area volunteers and current emergency personnel. The McIntosh County Health Department also provided training to high school students in the local school district. The first step in implementing the project was to hire an EMS coordinator. The individual selected was a paramedic and an EMS instructor. The project also hired another paramedic to assist in implementing the project.

Innovative Solutions to Problems

Two levels of emergency medical technician (EMT) training were offered. The EMT/basic courses included first-responder courses and safe baby-sitting classes. The EMT/intermediate courses included extraction courses, emergency vehicle operator courses, cardiopulmonary resuscitation (CPR), other emergency services, and cardiac life support classes. In the final year of the grant, the EMT/basic course was also offered at Ashley High School. Ten students participated in the course and were given

credits for the class. None of the students has tested for certification; however, the course has captured the interest of several high school students.

Results

As a result of the training funded by the grant, nine first responders were certified, five individuals completed the EMT/Basic course, and three persons completed the EMT/Intermediate course. The project also trained three EMS instructors and one CPR instructor. Emergency and first aid certifications were awarded to area lifeguards and day care providers who completed their training. In all, 35 people received training as a result of outreach grant funding. Unfortunately, the project experienced difficulty in retaining trained personnel. Many of the individuals trained have left the community or have taken jobs that do not allow them to provide emergency services. Both of the paramedics who were hired have relocated to larger communities to expand and further develop their careers. The paramedics were replaced with a local individual who is pursuing training in the paramedic field and an EMS instructor who is currently providing EMT training for the program.

In spite of these challenges, the Ashley Fire Department is now certified in "Heavy Rescue," and the ambulance service has been strengthened by an increase from 13 active members to 16 active members.

Potential for Replication

The primary barrier to EMS services in rural areas is recruiting volunteers who are willing to make the time commitment and meet the training requirements. The sacrifices that emergency workers have to make when they are on call increases substantially when there are not enough trained personnel.

For communities that are pursuing this type of program, it is recommended that the EMS coordinator, if possible, be hired from within the community. Community residents are often more likely to serve the community for a longer period of time—perhaps even for a lifetime. Individuals from outside the community often are willing to stay only long enough to gain experience, at which point they are likely to seek opportunities in larger communities.

After the Grant

The Ashley Medical Center will continue to employ an EMS coordinator after the grant. When the coordinator is on ambulance duty, the medical center will be the ambulance service for actual time worked. The medical center is also seeking opportunities to collaborate with other EMS entities to share training costs.

Population Served

Finding ways to deliver course content to students scattered across 20,000 square miles is a challenging endeavor. Such was the case in rural North Dakota, where there was a dire shortage of nurses. The area targeted by Project Transcends was originally limited to the northeast quadrant of North Dakota. Special emphasis was placed on providing training for Native American students, especially those willing to serve in Indian reservation health facilities.

Services Offered

The Project Transcends consortium included a variety of educational institutions and the North Dakota Health Education and Research Foundation. Lake Region College in Devils Lake coordinated the delivery of prerequisite courses to students. This occasionally involved contracting with other colleges in closer proximity to students. A tribal college also participated as a member of the consortium and offered prerequisite courses. This cooperative effort was designed to integrate the health care cultures of Indian and non-Indian students. Recruitment and Retention of American Indians in Nursing (RAIN) staff from the University of North Dakota focused on merging the two cultures into the nursing curriculum.

The major focus of the project was to develop and deliver a nursing curriculum, using distance education technology, to rural communities experiencing serious nursing shortages. Successful implementation of the project would allow local health care facilities to sponsor residents of their communities who were pursuing an associate degree in nursing and licensure as licensed practical nurses. Local clinics, hospitals, and nursing homes would employ the nurses upon completion of their studies.

Prerequisite and nursing courses were adapted for distance education using computers, interactive video, traveling faculty, and block scheduling. All educational expenses were paid by the project, and many students received stipends from their sponsoring facility. Classes were designed to allow students to remain in or close to their communities. Project participants repaid the cost of their education through employment with local health facilities for a predetermined length of time.

NORTH DAKOTA

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Innovative Solutions to Problems

Innovative teaching methods through Web sites used lecture notes produced in Microsoft Office software that were transformed into an HTML format. Another method for teaching distance learners involved Intrakal, a course management software whereby lecture notes, individual grades, chat rooms, and testing are accessed over an Internet or intranet connection via specific codes and passwords assigned to students. Students also benefited from the use of Weblearner, a lecture tool that produces file information that can be uploaded to the World Wide Web. The lecturing instructor is videostreamed so that audio and video are integrated along with the visual demonstrations of the software or any live lab experience one would have in a classroom situation. Students connected to an electronic classroom, asked questions, and viewed lectures. Clinical experiences were conducted in rural hospitals, when possible, and were block-scheduled for students who had to travel a long distance. Clinical segments of the curriculum were more traditional in nature.

Results

As a result of the outreach grant, 40 nurses will enter the work force in rural North Dakota and on Indian reservations in the State. Nine of the students are American Indians. The project also demonstrated the success that can be achieved by using distance learning as a means to train health care providers. A statewide task force has been assembled to study and implement many of the lessons learned in Project Transcends. Although the desired integration of a cultural excellence unit incorporating both Indian and non-Indian health cultures within the nursing curriculum has not occurred, the process of trying to do so significantly increased understanding of the topic.

Potential for Replication

Distance education for nurses and other health care providers can be successfully achieved, but it is expensive. Field counselors also play an important role as liaisons between college faculty, students, employers, and program staff, and in ensuring that the educational experience yields a favorable outcome. Modern technology allows the educational experiences needed for the training of nurses wherever 8 to 12 students can assemble within driving distance of a facility appropriate for clinical experiences.

After the Grant

Staff are currently evaluating ways to assist health care facilities that requested the program in other parts of North Dakota. Coalitions of health care providers and students are working together to secure funding for future activities. Work is under way for finding ways to improve financial aid opportunity for distance education, and the State task force is considering cost and budget allocations for distance education.

NORTH DAKOTA

GOLDEN HOUR EMERGENCY ACCESS RESPONSE TEAM

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Population Served

The Golden Heart Emergency Medical Service served a frontier region that covers 3,500 square miles and 13,000 residents in five counties. Nearly 25 percent of the population is aged 65 years and older. The region's economy is primarily agricultural, with large acreage farms and ranches. The population density in the area was 3.8 persons per square mile.

Services Offered

The Golden HEART (Golden Hour Emergency Access Response Team) project was developed to expand and improve the existing emergency medical services (EMS) system in north-central North Dakota. It was built on a cooperative team approach that involved the collaboration of volunteer ambulance services, local fire and rescue teams, and first-responder units in seven area communities. Before the project was created, there were two services likely to close their doors and no longer provide EMS and transportation. All of the services were struggling to find volunteers and the funding to support themselves.

Golden Heart EMS involved volunteer ambulance services in Esmond, Leeds, Maddock, Rolette, Rugby, Towner, and Willow City. These volunteers provide basic life support and medical transportation, responding to more than 600 requests each year. They respond to the request, initiate treatment, and provide transport to the closest appropriate facility. Golden Heart EMS provided medical direction, education, and community awareness programs, as well as administrative support, such as third-party billing, group purchasing, tracking of education requirements, and establishment of new service providers in underserved communities.

Innovative Solutions to Problems

Working with neighbors is nothing new for North Dakota. Co-op grain elevators rise above the prairies like skyscrapers and can be seen for miles. In a co-op, everyone pools the available resources, and everyone has an equal voice. This has not generally been the case in the EMS community. EMS systems have historically been very independent and somewhat reluctant to change. The Golden Heart project was the first in the State to offer emergency medical technician (EMT)-basic classes in public

schools, which has generated more volunteers and increased community awareness of the problems EMS systems face. When the Leeds ambulance service closed its doors because of a shortage of volunteers, the community and Golden Heart EMS systems enlisted nurses, first responders, and anyone with a license who was willing to help. An EMT-basic class was offered, and seven students were soon certified to run the service. The ambulance service has since re-opened and is going strong.

Results

During the 3-year period, Golden Heart EMS has responded to more than 1,200 calls and provided advanced assessment and treatment to 70 percent of these patients. The Leeds Ambulance Service now has 12 EMTs and more than 10 first responders who can arrive before the ambulance. They have generated enough funds to purchase a new ambulance. Willow City, which had closed its doors because of the lack of EMTs now has five EMT-basics, and four have just completed the EMT-intermediate class. The program has also helped organize and train first responders in the Wolford and Dunseith communities. Both communities are 30 miles from the nearest emergency medical care and had never had an organized emergency medical service.

One newly instituted component that was not originally part of the project is the critical care transport ambulance service. Heart of America Medical Center used to rely on ambulance services 60 miles away to transport critical patients who needed tertiary care. The medical center now operates its own service, which uses EMT-basics, intermediates, paramedics, registered nurses, respiratory care personnel, and physicians when needed. Since its inception in February 1999, the critical care transport service has served 160 patients.

Potential for Replication

A project like Golden Heart EMS would be an ideal model for a statewide or multiple countywide system in which government organizations provide funding. Other communities could implement the model by pooling their resources and implementing a first-response or intercept advanced life support program. Such a program could have a powerful impact on areas that currently have inadequate EMS.

After the Grant

Golden Heart EMS will continue all of the services developed with outreach grant support. These include advanced life support intercept to seven volunteer ambulance services and two first-responder groups, EMS education, liaison to the local team members, community education and prevention programs, EMS education to all North Dakota EMS systems upon request, an American Hospital Association community training center, billing services for 36 State ambulance services, critical care ambulance transports, and data entry for EMS data collection.

OHIO

BEHAVIORAL MEDICINE FOR CHILDREN: DEVELOPING AN INTEGRATED DELIVERY MODEL FOR APPALACHIAN CHILDREN

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Population Served

Based on national estimates of mental health problems among children and adolescents, it is estimated that there are approximately 7,300 young people living in 7 southern Ohio counties who need mental health services. Of these, approximately 2,000 have serious emotional disturbances that affect their ability to function effectively at home, at school, or in the community.

Children and families living in the service area targeted by the project often experience numerous geographic and economic barriers to behavioral health services—hilly terrain, the remoteness and isolation of communities, lack of public transportation, and chronic poverty. These factors pose significant barriers to accessing services, recruiting health professionals, and effective communication among health professionals.

Services Offered

The Southern Consortium for Children (SCC) is a collaborative of four alcohol, drug addiction, and mental health services boards that have worked in partnership for 12 years to deliver behavioral health services to remote, rural areas that are underserved by physicians and other health professionals. Although the grant covered 7 of the 10 counties served by the consortium, additional funding was obtained to include the remaining 3 counties in the program.

The consortium consisted of the Southern Consortium for Children, which served as the project's fiscal agent and provided overall program management; four local mental health agencies, which provided psychiatric, nursing, case management, counseling, crisis management, and support services; two child psychiatrists, who prescribed and monitored medications; two clinical nurse specialists, who offered medication monitoring services; and the Ohio University College of Osteopathic Medicine, which installed, managed, and maintained the project's education and consultation video teleconferencing system.

The services provided through the grant fell into two main categories—direct services and education/consultation. The direct services provided by the psychiatrist/nurse collaborative practices included psychiatric assessment for children and adolescents, prescribing and monitoring medications, and client and family

education. Most clients (65 to 75 percent) receiving direct services were Medicaid-eligible children aged 4 to 18 years. Education and consultation services were most often provided via the Behavioral Pediatric Case Seminar Series. Initiated in September 1998, each program in the series consisted of a case study presented to a panel comprising a child psychiatrist, a clinical nurse specialist, and a psychologist. After the panel's review of the case, the audience is permitted to ask questions. Each program was presented via video teleconference to 7 sites scattered throughout the 10-county region. As of May 2000, 604 individuals—including physicians, nurses, psychologists, social workers, medical students, school counselors, and others—had participated in at least 1 Behavioral Pediatric Case Seminar Series. As many as 60 individuals regularly attend the seminar series.

Innovative Solutions to Problems

What made this model unique was that it helped free psychiatrists from the responsibility of providing follow-up services, permitting them to focus their time and energy on children and adolescents with the most severe emotional disturbances. Instead, follow-up care was provided by clinical nurse specialists, who were responsible for monitoring medications and evaluating each child's progress. Follow-up care provided by clinical nurses eased the burden on psychiatrists and made it easier for children, adolescents, and their families to receive follow-up care at more convenient times. This approach is especially important in a region where child psychiatry services are extremely limited. As a result, children and families no longer have to wait 6 to 9 weeks for psychiatric services. Such services are now available in a week or less. And instead of having to wait about 7 weeks for follow-up care, such services are now available in 3 weeks or less.

Results

The outreach grant played a major role in increasing access to psychiatric services for children and adolescents. The child psychiatrists see an average of 52 clients per month. The clinical nurse specialists average nearly 100 clients per month. In all, the clinical nurse specialists have seen an estimated 3,555 clients and provided nearly 2,000 billable units of care since April 1998.

Advanced practice nursing is a powerful tool for expanding physician services and increasing quality of care—especially in an area characterized by a shortage of health care professionals and a large number of at-risk children and families. Additionally, video teleconferencing can be a valuable resource for improving communication among health professionals, for providing training, and for decreasing travel costs.

Potential for Replication

Using advanced practice nurses would work well in other rural settings as a means to enhance health care services, particularly in those States where nurses already have prescriptive authority. Their level of skill, advanced training, and autonomy make them an ideal choice for rural and other underserved areas, and their comparative low cost can benefit communities with limited resources. It is critical that communities and agencies served by advanced practice nurses recognize their value but understand that there is usually a dramatic difference between advanced practice nurses and nurses with associate or baccalaureate degrees.

While video teleconferencing is valuable, it is also expensive. The ongoing costs associated with the system are $5,400 annually per site for the T1 telephone line and $1,500 annually for maintenance. However, when the system is used for direct service, it will be a self-supporting effort.

After the Grant

The project continues to operate with revenues generated by the collaborative practices, fees for videoconferencing services, and consortium funds. The consortium is currently negotiating with the Ohio Department of Mental Health (ODMH) to connect the SCC network with the statewide Department of Administrative Services network. This endeavor would significantly increase access to statewide ODMH videoconference programming.

Population Served

American Indians living in west-central Oklahoma generally accept the fact that diabetes and hypertension are at epidemic proportions—and deadly. Many believe that one can somehow "catch the sugar" (diabetes) or that one is "given" hypertension. Many people with hypertension are ill-advised to take water pills. Few accurately understood the connection between diabetes and vascular disease, amputations, and blindness. Similarly, few recognized the relationship between hypertension, diabetes, and renal failure. Old nutritional habits, lack of exercise, and the common perception that obesity is a sign of health and strength perpetuated unhealthy behaviors.

Some 20 percent of the population (8,000 persons) served by the Health and Wellness Consortium of Western Oklahoma had diagnosed diabetes, and 23 percent had chronic hypertension. Of those who had diabetes for 10 years, 55 percent had retinopathy. Of the 120 patients who received eye examinations, 73 had cataracts, glaucoma, or significant diabetic retinopathy. One-half of all deaths from vascular causes in people with diabetes were attributed to renal disease compared with only 11 percent of the U.S. general population. In spite of these serious public health challenges, there were no diabetes- or hypertension-specific prevention or wellness programs available in the area.

Services Offered

The project was designed to serve an eight-county area in west-central Oklahoma where the Southern Cheyenne and Arapaho reservations are located. All but one of the counties were designated as medically underserved. The consortium consisted of the Cheyenne and Arapaho Tribes of Oklahoma, the governmental body that provides direct health care, follow-up, and wellness programs for the American Indian population in the target area. Its tribal health programs are the primary link between the patient and family, and the health and wellness plan for that family. The Southwestern Oklahoma State University Social Work Program sponsored the initial wellness conference, as well as quarterly health and wellness meetings for consortium agency and grant staff. The Indian Health Service (IHS) provided direct and indirect health care for American Indians in the service area. IHS providers take part in the health and wellness planning

OKLAHOMA

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for families served by the project and provide physical exams. The Center for Human Behavior Studies, an American Indian-controlled, nonprofit organization, served as the lead agency for the consortium and provided administrative support, fiscal management, and project coordination. The Cheyenne Cultural Center participated in project activities designed to promote lifestyle change and improve community organization and participation.

Together, the consortium members offered two models of behavioral intervention to individuals, families, and the community. The first model promoted the idea that individuals generally will take action to ward off or control ill health if they regard themselves as susceptible to the condition. The second model implemented social cognitive theory to overcome the notion that one is "given" or can "catch" diabetes or hypertension.

Innovative Solutions to Problems

Clients with diabetes and/or hypertension, as well as their family members, were actively involved in developing prevention and treatment plans. Strong emphasis was placed on involving families and communities in a culturally positive way. Community gatherings were used as opportunities to educate people about good nutrition, proper ways to exercise, and effective ways to self-manage diabetes and hypertension. Medical clinics, community dances, and powwow meetings also served as venues for culturally appropriate education.

One of the biggest challenges the project faced was getting clients to comply with their prevention or treatment plan. Some family members and friends pressured clients to continue their usual eating habits—consuming diets high in sodium, fat, and sugar. The program countered this challenge by positively channeling family and community pressures to encourage healthier lifestyles and participating in personal clinical surveillance. Program staff also worked with younger members of the community to revive the historical values of athletics and consuming natural foods.

Results

The project provided diabetes and hypertension prevention and treatment services to more than 14,300 individuals. The majority were adults aged 20 to 65, but it also served more than 700 individuals aged 65 and older, nearly 300 children aged 0 to 11 years, and nearly 300

adolescents aged 12 to 19. Throughout the grant cycle, the program offered 160 wellness and prevention meetings, 390 diabetes clinics, 450 health education classes, 66 community organization meetings, and 66 healthy food demonstrations.

The program succeeded in promoting lifestyle changes in nutrition and physical activity, modifying cultural norms in perceptions of a healthy image and lifestyle, encouraging individual responsibility for self-care, and increasing awareness of the relationship between diabetes and hypertension. The program also enhanced health and wellness planning and coordination among provider agencies and increased the knowledge of providers. These goals were accomplished, in part, because the Indian tradition of a "village" support system was used to promote communitywide change in both behaviors and attitudes.

One of the most important lessons learned by the project was the value of evaluation. Without evaluation, long-term continuity and planning is impossible. Evaluation enabled the consortium to identify its successes, better understand how activities related to project goals, and recognize the importance of allowing activities to evolve in response to community feedback.

Potential for Replication

The evaluation indicated that the project's approach and methods may work well in other rural ethnic communities. When local resources work together and within the cultural context of the target population, resources are maximized, programs are accepted, and services are used. Although it may be difficult to blend the perspectives and missions of clinical and community agencies, doing so is not an insurmountable challenge as long as partners are willing to negotiate.

After the Grant

The consortium agencies have pledged to continue the program's activities. However, due to limited funding, program efforts will most likely be limited to meeting clinical needs.

Population Served

The Rural Health Outreach School-Based Health Program was created to serve several sparsely populated counties in South Carolina, including Orangeburg, Bamberg, and surrounding areas. The service area covers nearly 1,900 square miles and is situated between the two larger metropolitan areas of Columbia and Charleston. Orangeburg is the largest of the contiguous counties in this entirely rural portion of the State. However, at least 30 percent of county residents live in the more geographically isolated outlying areas. The target population is largely medically underserved and is characterized by poverty and economic deprivation. In particular, children in the region lacked access to basic health promotion and disease prevention services. Children aged 0 to 17 represented 28.2 percent of the service area population, and nearly one-third of all children in the region live in poverty. The average annual per capita income in Orangeburg County is just over $9,000. While nonwhite individuals make up nearly 59 percent of the population, their average annual per capita income is only $5,965, and 77 percent of nonwhite children live at or below 200 percent of the poverty level.

Services Offered

Eleven organizations participated in the consortium. Family Health Centers, Inc., (the lead agency), the Orangeburg Department of Public Safety, the Orangeburg Sheriff's Department, the Orangeburg Mental Health Center, and the Orangeburg County Department of Social Services were the primary providers of services. They offered comprehensive medical evaluation and assessment, physical exams, vision and hearing screenings, nutritional assessment, dental screenings, mental health and substance abuse services, and violence and pregnancy prevention services. The local community action agency recruited and trained community health aides, conducted outreach, and assisted professional staff with health promotion and disease prevention activities. William J. Clark Middle School, Robert E. Howard Middle School, Hunter-Kinard-Tyler Consolidated School (K-12), and Holly Hill Elementary School provided access to students and space for service delivery. Orangeburg-Calhoun Technical College provided medical assistance training to community health aides so they could support clinical and professional staff.

SOUTH CAROLINA

RURAL HEALTH OUTREACH SCHOOL-BASED HEALTH PROGRAM
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School-based staff included a family nurse practitioner who performed physical exams, diagnosed acute and chronic illnesses, developed and monitored patient management plans, adjusted medications and other treatment regimens, and referred patients who needed hospitalization or specialty care as appropriate. The family nurse practitioner consulted with physicians and other members of the health care team to ensure each child and teenager received age-appropriate and comprehensive care. A licensed practical nurse provided assistance to the family nurse practitioner. In addition to distributing program information, consent forms, and health information through home visits and other community events, community health aides provided outreach for the State's Children's Health Insurance Program (CHIP) enrollment, coordinated community health fairs, and offered health education and peer counseling services.

Innovative Solutions to Problems

The services offered by the program were truly school-based in that most services were actually delivered at the schools. The project provided referrals to Family Health Centers, Inc., in Orangeburg or one of the four satellite clinics for children and adolescents who needed services that were not available on site. These included pediatric, obstetric, gynecologic, health education, social work, and dental services. When some school officials and parents objected to the program's efforts to provide sexually transmitted disease and pregnancy prevention services and maternity care for pregnant teens, the project made alternate arrangements by providing referrals to other service agencies.

Results

The project succeeded in meeting its overall goal of increasing access to care for school-aged children. The school-based health centers funded by the outreach grant provided nearly 11,000 units of primary care services and more than 3,100 units of dental screenings to 3,741 students. Nearly 70 percent of students who received services were adolescents aged 12 to 19, and 70 percent were female.

Potential for Replication

For school-based health programs to succeed, all partners involved in the effort must share their limited resources, and program activities must be properly coordinated. As resource-sharing and networking increased during the grant cycle, so did the program's success in service delivery, health education, and health promotion. In addition, when providing school-based services, it is essential that parents and members of the community be actively involved in program planning so they can "buy in" to the approach and express their concerns

about certain services. For example, many communities may be reluctant to support a school-based health program if they perceive that the primary function of the clinic will be to provide family planning services. Finally, the project learned that, to sustain a school-based health program, additional sources of reimbursement besides Medicaid and third-party payers are needed. Seeking other funding sources in the planning stage increases the likelihood of success and continuity.

After the Grant

The school-based health programs will continue to provide the array of prevention, screening, and health promotion services offered during the grant cycle. This is being accomplished by sharing resources among schools and consortium members. In the last year of the grant, the program placed strong emphasis on helping parents and guardians enroll their children in South Carolina's CHIP program. The project has also scheduled a golf tournament with the goal of raising $25,000 in additional revenues for the school-based health programs and will continue to seek additional grant funding.

Population Served

This project, located in central South Dakota, covered a 3,901 square mile service area with a 1994 population of 12,434 and a population density of only 3 persons per square mile. The area's demographic characteristics include a declining population base, outmigration, and an aging populace. South Dakota is one of the most rural States in the Nation, with approximately 13 percent of its population engaged in farming. Some 20 percent of the population in the target service area is employed in farm operations. Many young adults are leaving the region—seemingly in droves—searching for more opportunities, higher wages, and a different way of life.

The service area included Brule, Buffalo, Jones, and Lyman counties. Lyman County is home to the Lower Brule Indian Reservation, and Buffalo County is home to the Crow Creek Indian Reservation. Emergency medical services (EMS) in the region are provided by six rural ambulance services. A typical ambulance service is staffed by 5 to 15 volunteer emergency medical technicians (EMTs) and operates with older emergency vehicles and minimal equipment. Approximately 14 percent of those served by existing ambulance services in the region are aged 65 and older. (In two counties, elders account for 17 percent of those served.) The response time varies from 10 to 45 minutes, depending on location. In fact, portions of the service area are 60 or more miles away from the closest emergency room, underscoring the need for high-quality emergency medical services.

Services Offered

Eight organizations participated in the project consortium. Mid-Dakota Hospital served as the lead agency. Six area ambulance services were also involved, as was *The Chamberlain-Oacoma Register* (the regional newspaper). All consortium members were represented on the project's advisory council, which also included consumer representation. The primary goal of the project was to educate and train community members, ambulance service staff, hospital emergency room employees, volunteer fire fighters, physicians, dispatchers, law enforcement personnel, and others to increase their knowledge of EMS and to increase the number of available EMS providers. This was

SOUTH DAKOTA

ENHANCING EMERGENCY PREPAREDNESS IN CENTRAL SOUTH DAKOTA
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accomplished by sponsoring education and training opportunities for professionals and consumers throughout the four-county region. Grant funds were also used to update emergency equipment.

Innovative Solutions to Problems

The project sponsored a myriad of classes and trainings throughout the service area, ranging from basic and intermediate EMT classes, emergency room nurse training, a FarmMedic course, water rescue and CPR classes, emergency pharmacology, rescue driver training, hazardous materials classes, and several other educational opportunities. Given the expansive area covered by the project, ensuring that consumers and professionals throughout all corners of the region had access to education and training opportunities was no easy task. This challenge was complicated by the fact that most participants also had full-time jobs. Project staff took great care to ensure that training opportunities were adequately scattered throughout the area and to accommodate the schedules of volunteers and professionals seeking training.

Results

Although it is not known precisely how many people participated in the classes and trainings offered by the program, it is clear that a significant number of individuals and professionals in the region were interested in learning more about emergency medical care. Some 500 persons participated in an 8-hour CPR training course. Between 4 and 17 people participated in the FarmMedic, hazardous materials, water rescue, emergency pharmacology, emergency obstetrics and delivery, rescue driver, or emergency behavior training classes. The program delivered 8 EMT Basic classes at 110 hours each, 2 EMT Intermediate classes at 40 hours each, 50 emergency room nursing classes, and 6 first-responder classes at 40 hours each.

Potential for Replication

Many rural communities across the Nation lack sufficient EMS. Many residents assume such services are available—only to find out that emergency services do not exist when they or a loved one need emergency care. It is also difficult to generate interest in expanding or acquiring EMS expertise among members of the community. Therefore, this project involved a local newspaper in the consortium. Reporters and editors played an important role in keeping residents informed of the project's progress and educating communities about the value of EMS and the importance of ensuring that emergency medical personnel are adequately trained to function effectively in any situation.

One potential barrier other communities may encounter in implementing a similar model is competition among ambulance services. It also may be difficult to find competent course instructors.

After the Grant

The consortium hopes to build on the momentum generated by the outreach grant. Training sessions will continue to be offered to all area ambulance services. Fees will be established for all training sessions to offset expenses and to ensure that participants are committed to completing the course. In addition, training resources will be housed in a lending library and will be made available to other communities upon request.

TENNESSEE

A CHILD AND MATERNAL HEALTH PROGRAM FOR HARDEMAN COUNTY, TENNESSEE

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Population Served

Hardeman County is located in rural western Tennessee, approximately 60 miles from Memphis. The county consists of 655 square miles and nine incorporated towns. In 1996, 24,333 people lived in Hardeman County. Some 40 percent of the population are racial/ethnic minorities, and the average unemployment rate for the county is 8.8 percent.

Since 1993, the percent of low-birthweight babies in Hardeman County has been equal to or higher than the statewide average. The infant death rate per 1,000 births in the county increased dramatically from 1993 to 1995 (5.6 in 1993, 11.8 in 1994, and 22.8 in 1995). The neonatal rate in Hardeman County was also higher from 1993 to 1995 than statewide figures. The sexually transmitted disease (STD) rate in the county was 4,227 per 100,000, while the statewide rate was 2,092. More than 47 percent of the births in Hardeman County lacked prenatal care. At the time of application, the county was geographically designated as a health professions shortage area, a State-specified physician shortage area, and a physician shortage area for obstetrics.

Services Offered

The outreach grant was used for a multifaceted program designed to reduce teen pregnancy, low-birthweight babies, infant death rates, sexually transmitted diseases, lack of adequate prenatal care, child abuse, and neonatal deaths in Hardeman County, Tennessee. While the program placed strong emphasis on preventing teen pregnancy, the program recognized that pregnancies would occur. In such cases, the program worked to ensure that babies would be born healthy and develop normally.

Innovative Solutions to Problems

The first program component was the assignment of a full-time adolescent pregnancy prevention coordinator in the Hardeman County Health Department to work with the local Teenage Pregnancy Prevention Council. (The West Tennessee Regional Health Department assumed the responsibilities of the Hardeman County Health Department for the last 10 months of the grant period.) The Hardeman County Community Health Center

and Hardeman County Board of Education played prominent roles in the Council. The second program was a modified Healthy Start program. Bolivar General Hospital and the Exchange Club-Carl Perkins Center for the Prevention of Child Abuse worked on the Healthy Start program. The third component was in-home parent training for families referred from multiple community agencies. This service was provided by the Exchange Club-Carl Perkins Center for the Prevention of Child Abuse. The final program component was the provision of legal assistance and counsel to families involved in the Healthy Start program and in-home parent training. This service was provided by West Tennessee Legal Services. The program also offered teen sexuality workshops designed for girls and their mothers and boys and their fathers.

Results

During the grant period, 208 families were served by the Healthy Start program. Some 71 children received well-baby examinations, and more than 50 children received developmental screening and follow-up services. In addition, 84 children from target families received all appropriate immunizations by 2 years of age.

Approximately 150 families benefited from parent training, and another 240 families received some kind of legal assistance, ranging from legal assessment to legal education to indepth legal counsel. The program also offered 12 teen sexuality workshops per year. Eight of the workshops targeted girls and their mothers, while four targeted boys and their fathers. More than 2,000 individuals participated in the workshops. The program also sponsored several teen health fairs, community teen forums, school task forces, and the development of teen resource information cards. The resource information cards were distributed to nearly 2,000 Hardeman County teens.

Potential for Replication

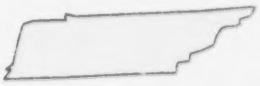
The Healthy Start and parent training programs have developed standard training components, protocols, data collection instruments, data recording methods, and a wealth of documented information. The adolescent pregnancy prevention component is a modification of a program being implemented in five urban areas in Tennessee. The legal component could be replicated by using a legal services organization designed to serve individuals with fixed or limited incomes. Overall, each component of the program could be replicated in other rural areas or communities.

The biggest challenge is finding and recruiting qualified staff. For many rural areas, hiring staff could be a difficult process.

After the Grant

The Healthy Start component of the program was discontinued in October 2000. The in-home parent training program will continue through a State grant and through private donations to the Exchange Club-Carl Perkins Center for the Prevention of Child Abuse. The work of the adolescent pregnancy prevention coordinator will continue through funding from the West Tennessee Region Department of Health. Legal services will be offered as United Way funding permits.

TENNESSEE



LEWIS COUNTY RURAL OUTREACH PROGRAM
COLUMBIA AREA MENTAL HEALTH CENTER
HOHENWALD, TN

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Population Served

The Lewis County Rural Outreach Program targeted low-income residents of Lewis County, Tennessee, who did not have money or insurance to pay for mental health, substance abuse, or related support services. Pregnant teens and teen parents were targeted for rental assistance services. The elderly, disabled, and pregnant teens were offered transportation services to access health care and hospital services. The grant also targeted homeless persons and those who were in transitional housing. Although the program was specifically designed for these populations, the project was available to all county residents.

Services Offered

The project offered alcohol and drug abuse treatment, mental health services, medical assistance, support services for teen parents, transportation services, patient supplies, and community education and outreach. These services were made available through the collaboration of five area agencies: Columbia Mental Health Center, Buffalo Valley Alcohol and Drug Treatment, the Lewis County School System, the Community Home Health agency, and Home Ties—an in-home crisis intervention and family education program. In October 1998, Community Home Health left the consortium because it closed, and the Lewis County Health Council joined in its stead.

Columbia Mental Health Center served as the lead agency. In addition to managing and administering the grant, the center provided a case manager who conducted community outreach and worked closely with the school system and other community and faith-based organizations. The case manager also screened applicants to determine their eligibility and worked with various vendors to ensure proper billing and payment for services rendered. The mental health center provided both on-site and off-site mental health services.

Buffalo Valley Alcohol and Drug Treatment Center provided substance abuse treatment services and provided referrals. The Home Ties program referred pregnant teens, teen parents, and their family members. The Lewis County School System referred pregnant teens and teen parents to the program so they could receive housing services and transportation for prenatal care. It also provided a location for a parenting class. Community Home

Health gave patient supplies to eligible residents and made referrals to the project. The Lewis County Health Council also made referrals to the program.

Potential clients were required to apply for at least one service offered by the grant, and they were allowed to reapply at the beginning of each program year.

Innovative Solutions to Problems

At first, the program experienced difficulty obtaining referrals to the project. Because this was a new project in the community, many Lewis County residents did not trust the program and had to be educated about the services and the eligibility requirements. This barrier was overcome by sending the case manager and another mental health staff member to referral sources, generating news coverage of the program, distributing flyers throughout the community, and arranging for speaking engagements at community events. As a result, referrals to the program increased, especially among elderly and disabled persons.

The project also had expected a greater need for housing assistance and transportation among pregnant or parenting teens. Since many teens received financial support from their families, the need for these services was not as great as the program had expected.

Results

A total of 367 individuals received services through the project. During the grant reporting period, 67 individuals were approved for alcohol and drug abuse treatment, and 81 were approved to receive mental health services. Nearly 200 were cleared to receive medical assistance, while 186 applications were approved for transportation and 201 for patient supplies. Four persons received rental assistance. Nearly 40 percent of clients were adults aged 20 to 64 years. Another 40 percent were persons aged 65 and older. The vast majority of clients were Caucasian. More than 61percent of clients lived at or below 100 percent of the poverty level, with 39 percent of those between the 101 and 199 percent levels.

The program evaluation revealed that increased communication among consortium members was critical in assessing the unmet needs of individuals and families living in this rural community. The evaluation also showed that it takes time to implement a new program, because informing the public about services and establishing trust with potential clients is a time-consuming process. Computer systems also proved to be valuable tools in maintaining data and managing the project effectively.

Potential for Replication

This service model could be readily replicated in other rural communities, as long as Medicare does not cover prescriptions and certain supplies (e.g., glasses for noncataract patients, dentures, etc.). This model is especially relevant to rural communities with large elderly and disabled populations.

The main problem other communities may experience in replicating these services is reaching pregnant or parenting teens. Although data supported the need for these services, they expressed little interest in receiving housing assistance and transportation services.

After the Grant

The consortium will continue to seek out new funding to continue the project or create a new project to benefit Lewis County residents.

Population Served

About a decade ago, portions of southwest Texas suffered the effects of a devastating flood, which was followed by a 10-year drought. Terrell County produced 1.6 million pounds of wool and mohair in 1994, but 1999 saw only 100,000 pounds of wool and mohair produced in the county, due largely to the loss of Government price support. In recent years, three of five farmers have had to shut down. In 1995, when the Southern Pacific Railroad pulled out, 51 families lost their primary or only source of income. Today, the largest single employer in Terrell County is the Terrell County government itself. The average income per household is just under $23,000 per year, and poverty is rampant.

Residents of Sanderson Canyon live quietly. They know and like their neighbors. They take walks without locking doors, and the pace of conversation is noticeably slow. Sanderson schools are rated among the best in the State, and several churches provide an opportunity for residents to freely practice their faith.

Based on 1995 U.S. Census data, 14,065 people live in Pecos County, 1,465 people live in Terrell County, and 9,998 people live in Brewster County (the largest county in the State). The area spans 8,570 square miles, with an average of only 1.9 people per square mile. One of the region's biggest tourist attractions is Big Bend Park, and the area now serves as a summer retreat to "almost retired" couples from Houston, Austin, and other large cities who seek personal isolation in a scenic and beautiful environment.

Services Offered

The Trans-Pecos Rural Health Initiative is a four-organization, two-site collaborative. The project is administered through Pecos County Memorial Hospital in Fort Stockton in collaboration with Sanderson Health Care Center, Big Bend Regional Medical Center, and Marathon Primary Care Center.

The grant made it possible to create a three-county primary care alliance with two vertical networks. These networks combine two hospitals, two rural health clinics, and schools for health care and provides a facility for emergency medical services, as well as services of the Texas Department of Health, the Women, Infants, and Children program, and the Department of Health and Human Services. The program furnished each clinic with a nurse practitioner, a nurse, and a clerk. A medical doctor supervised the clinics and saw patients at least once a week.

TEXAS

THE TRANS-PECOS RURAL HEALTH INITIATIVE
PECOS COUNTY MEMORIAL HOSPITAL
FORT STOCKTON, TX

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The program was designed to address the health needs of local residents, travelers, and adolescents by providing disease prevention and health promotion training to health professionals and school personnel, offering ambulatory and mental health care for underserved populations and local residents, enhancing the quality of emergency medical services, and increasing access to health care through outreach.

Innovative Solutions to Problems

One of the basic goals of the initiative was to strengthen the infrastructure of the two clinics funded by the grant. That meant focusing on more basic needs—such as purchasing exam tables, binocular microscopes, autoclaves, digital thermometers, electric hyfercators, electrocardiographs, and other equipment commonly found in clinics. However, the project also placed strong emphasis on outreach. For example, staff at both clinics spent a great deal of time reaching out to families and coordinating their efforts with local schools.

Results

The primary goal of the project was to expand primary care services throughout the region and connect 520 additional families to a routine and reliable source of health care. The Marathon Primary Care Center was refurbished so that it can use updated equipment to better serve the health care needs of local residents, area ranchers, and visitors to Big Bend Park. The Marathon clinic serves a community of about 700 people in Brewster County. The clinic provides immunizations for children, physical exams for school athletes, emergency trauma treatment for accident victims, and blood and pregnancy tests. Information on birth control is available to clients, and treatment for sexually transmitted diseases is provided. The clinic also offers blood pressure and weight reduction programs to help control the onset of diabetes and other diseases commonly seen in rural areas.

Approximately 10 percent of those who receive care at the Marathon clinic are tourists. In addition to serving local ranchers and townspeople, the clinic provided care to visitors from Maryland, Wisconsin, Michigan, Mexico, and other parts of Texas.

Of those served at the Marathon clinic, 20 percent were aged 0 to 19, 37 percent were aged 20 to 64, and 35 percent were aged 65 and older. Some 35 percent of clients were Medicare beneficiaries, while 15 percent were Medicaid beneficiaries. Only 30 percent of those served had private insurance.

The Sanderson Health Care Center also updated its equipment and furnishings, increased its medical supplies, and offers a more experienced staff. The Sanderson clinic extended its hours of operation to 3 days a week so that it could meet the health care needs of travelers, new retirees, area ranchers, and local residents. In 1999, the clinic served 669 individuals; 35 percent were aged 65 and older, and 25 percent were younger than age 20. Of those served at the Sanderson clinic, 66 percent had either Medicare, Medicaid, or private insurance coverage. Nearly one-quarter "self-paid" for services.

Potential for Replication

The Trans-Pecos Primary Care Initiative is a model for any rural organization or agency seeking to establish a medical home for those who live in the community. Although rural communities may be farflung and geographically dispersed, families and workplaces can play a powerful role in overcoming geographic barriers and creating healthier communities. In addition to requiring a reliable source of basic health care, families need basic knowledge of how to control their health.

After the Grant

Both the Marathon and Sanderson clinics continue to provide health care services to local residents, ranchers, and tourists. In addition, a new physician has joined the Sanderson Health Clinic—the first medical doctor to call Sanderson "home" in more than 10 years.

VERMONT

CREATING HEALTHY ADOLESCENTS—A MODEL PREVENTION PROJECT (CHAMP)

STATE OF VERMONT

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Population Served

Creating Healthy Adolescents—A Model Prevention Project (CHAMP) targets children in State custody and their foster families. Substance abuse is a serious public health challenge in Vermont and is strongly associated with poverty, crime, and domestic violence—as well as an estimated $582 million in health care costs. It represents the leading cause of death in the State, with tobacco and alcohol responsible for more than 25 percent of all deaths. Nearly 80 percent of children and adolescents in State custody come from families with a history of substance abuse, and many adolescents already show signs of substance use when they come into State custody.

Services Provided

CHAMP's primary goal was to develop a new foster-home-based health service model designed to reduce substance abuse among adolescents in State custody. Since 85 percent of Vermont's children in custody are placed in foster care, foster parents were identified as the target for CHAMP trainings, health education, and other services. Originally, the project focused on foster parents in the Bennington district of the State. By the end of the third year, however, newsletters, mailings, and a smoking cessation program were available to foster parents throughout the State.

Originally, CHAMP was agency-based and local. However, over the 5 years of the project, it evolved into a statewide, participant-guided consortium, in which foster parents were actively involved in organizing program activities, along with Child Protective Services, the Department of Health, a parent/child center, and State and local foster parent organizations.

Innovative Solutions to Problems

Targeting foster parents and crafting services to enhance their parenting and prevention skills became the innovative crux of the CHAMP program. The project placed strong emphasis on creating family-centered services and recognizing the achievements of parents. In addition to receiving educational materials and training, foster parents who participated in project-sponsored health fairs were provided meals, prizes, entertainment, and other incentives. The substance abuse training program was based on an

integrated child welfare curriculum that incorporated issues of primary concern to foster families, such as domestic violence, trauma, attachment disorders, and resiliency.

When CHAMP first started, the goal was to develop "substance-free foster care" for at-risk teens. Since many foster parents viewed the emphasis on "substance-free" as a negative message, staff members refined the program's approach to a more positive message that promoted the concept of healthy living. Services were expanded to include a broader array of health education and support services for foster families, such as exercise, nutrition, dental hygiene, stress management, healthy family activities, and conflict resolution. In addition, viewing foster parents as partners in the effort rather than clients provided a source of empowerment for foster parents. Even something as simple as hiring a few parents as part-time staff played a major role in legitimizing the project among foster parents, recruiting families to participate, and tailoring services to each family's unique needs.

The program implemented two other innovative ideas. Upon completion of 10 hours of training on substance abuse and child welfare issues, foster parents who committed themselves to creating a safe and healthy home environment and setting clear rules about substance use were eligible to be declared as living in "a CHAMP home." Another initiative, called "CARES," offered intensive training for adults and curriculum-based prevention activities for preschool through adolescent children. To accommodate families' busy schedules, the training was offered on Saturdays. Many participants lauded the program as the best training they had ever received.

Results

During the grant period, a total of 50 homes achieved "CHAMP home" status—38 of which were located in 3 target districts. A total of 48 people participated in the 10-hour substance abuse and child welfare basic training program. CARES training was provided to 63 adults—many of whom later reported significant behavior changes as a result, including quitting or reducing smoking, quitting or reducing alcohol consumption, or locking up medications. Some 350 people participated in CHAMP-sponsored health fairs, while approximately 1,500 people attended 6 foster parent support conferences that were at least partially funded by CHAMP. Health education materials were delivered to 50 foster homes, and some 1,000 foster families received the program's *Healthy Living* newsletter. Nearly 500 contacts with foster families at other CHAMP events were documented during the course of the project, and 45 foster parents or teens in foster care received smoking cessation support.

One of the most important lessons learned was that engaging foster parents as project advisors had a major and positive impact on the range and quality of services offered. Another valuable lesson learned was that collecting needs assessment survey data shed new light on the extent of substance abuse and related problems in the target population and was helpful in developing and refining project activities.

Potential for Replication

Given that substance abuse prevention and treatment services in rural areas are generally hard to find, many communities would be interested in a program model that promotes healthy living in foster homes, using knowledgeable parents to serve children and teens from addicted families. CHAMP project staff members are developing a series of products that may be useful to other communities, including a 2-hour preservice training curriculum, a 10-hour core curriculum for foster parent groups, and an 18-hour, 3-day family training modeled after CARES. These products will be available for training health and child welfare professionals to use in their work with foster parents. Staff members are also developing a "blueprint" for establishing CHAMP homes and a guide on how to successfully organize a foster family health fair.

Replicating this model, however, may not be an easy task. State or county child welfare or protective service agencies are, by necessity and law, regulatory organizations that focus on immediate safety and placement. Any attempt to improve such a system or build capacity requires leadership, vision, and persistence. Staff must establish credibility and earn the trust of foster parents.

After the Grant

CHAMP continues to offer training for foster parents. Parents who have maintained CHAMP homes now serve as mentors for new CHAMP homes and are offered advanced substance abuse training at foster parent conferences. The program also continues to sponsor a range of health education initiatives, including a statewide smoking cessation campaign and annual foster parent health fairs. The State foster parent association continues to offer a newsletter and Web site for foster parents and agency staff.

WASHINGTON

YAKIMA VALLEY FARM WORKERS CLINIC (YVFWC)
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Population Served

The town of Yakima is home to a large population of children with special health care needs. Some of these young people were born with fetal alcohol syndrome, while others suffer from cardiopulmonary problems, neurological defects, or speech or hearing problems.

Yakima is also a medically underserved area where poverty is rampant and the lack of health insurance is a widespread challenge. Many parents find themselves in the difficult position of wondering *where* and *how* their child's special health care needs will be addressed.

Services Provided

The Yakima Valley Farm Workers Clinic (YVFWC) provided dental screenings and treatment, pediatric medical evaluations, nutritional assessments, and referrals to cardiology, orthopedic, neurology, and pulmonary services. The program also offered a range of mental health services, such as short-term counseling and behavioral assessments, as well as fetal alcohol syndrome services, genetics testing, speech and hearing services, and occupational and physical therapy programs. A pediatrician and psychiatrist participate in the program's multidisciplinary review teams.

The consortium consisted of as many as eight local community and service agencies, including Yakima Valley Memorial Hospital, the Catholic Family and Child Service, Central Washington Comprehensive Mental Health, Enterprise for Progress in the Community, Hearing and Speech Services, Providence Yakima Medical Center, the Memorial Foundation, and the Yakima Valley Farm Workers Clinic. Together, these organizations were able to provide children with special health care needs with a broad array of medical, dental, behavioral, and specialty health care services.

Innovative Solutions to Problems

The program implemented an integrated/co-located model that increased client access to the medical expertise of service providers representing 14 different agencies. For families who were unable to travel, the YVFWC joined forces with Yakima Memorial Hospital to open a satellite clinic in Sunnyside, Washington, which is about 1 hour from Yakima and has a large

migrant population. As a result of this collaboration, children with special health care needs throughout the region gained access to a whole new range of services, including specialty clinics and occupational and physical therapy programs.

Results

Units of services provided to children with special health care needs increased substantially during the course of the project. In 1998, nearly 1,000 units of services were provided—more than half of which consisted of medical services. In 1999, dental services made up more than half of the service units provided. In 2000, the program provided 1,742 units of dental services, 1,338 behavioral assessments, and 554 units of medical services to 1,241 children and adolescents. Some 97 percent of the children served in 2000 were aged 11 and younger, and nearly half were of Hispanic origin.

Potential for Replication

The integration/co-location model played an important role in increasing access to care, improving the quality of care, and reducing health care costs for children with special health care needs and their families. Such a model could be particularly useful for rural communities seeking to increase access to care for children with special health care needs and to make the most effective use of limited community health care resources.

After the Grant

The Memorial Foundation contributed approximately $90,000 over the course of the 3-year project to help support the work of the behavioral assessment team. These funds will not be available in the future. However, the Memorial Foundation has agreed to help cover the costs of the specialty clinics in future years so that children with special health care needs will be able to receive those services. The YVFWC anticipates approximately $245,000 in funding from insurance reimbursements and fee-for-service revenue. Meanwhile, the program is seeking new grant opportunities to help reduce cost-per-encounter expenses. In fact, it was recently awarded a community integrated service system grant totaling nearly $50,000 for 3 years.

WISCONSIN

TRI-STATE RURAL HEALTH PARTNERSHIP
WISCONSIN COULEE REGION COMMUNITY ACTION PROGRAM, INC.
WESTBY, WI

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Population Served

The Tri-State Rural Health Partnership targeted a predominantly rural service area that spanned both sides of the Mississippi River—Allamakee County in Iowa, Houston County in Minnesota, and Vernon County in Wisconsin. All three counties are designated as medically underserved areas. Although there has been a recent influx of Hispanics moving into the region, the vast majority of residents are Caucasian. Many are dairy farmers who are feeling the effects of depressed milk prices. There is also a large population of older people in the region.

Unlike similar health care programs in other parts of the Nation, the Tri-State Rural Health Partnership chose not to focus exclusively on meeting the health care needs of the poor. In fact, many of the program's services were offered to the general public. The local economy is generally strong, although in the last several months of the grant cycle, local families and businesses involved in the dairy industry increasingly found it difficult to make ends meet. In spite of a healthy economy and generally higher socioeconomic status, community health needs assessments revealed that local residents lacked access to health promotion and disease prevention programs, as well as basic health care services. Special concerns for the service area included heart disease prevention, school health services, and osteoporosis prevention.

Services Offered

Seven organizations make up the Tri-State Rural Health Partnership. The Wisconsin Coulee Regional Community Action Program, located in Vernon County, Wisconsin, served as the fiscal agent, lead agency, and a service provider. Other consortium members were the Northeast Iowa Community Action Corporation (Allamakee County, Iowa); the Southeast Minnesota Community Action Corporation (Houston County, Minnesota); Vernon Memorial Hospital (Vernon County, Wisconsin); Veterans Memorial Hospital/Public Health Agency (Allamakee County, Iowa); Houston County Public Health Agency (Houston County, Minnesota); and Gundersen/Lutheran Medical Center (La Crosse, Wisconsin). A representative of the University of Wisconsin-La Crosse served as project evaluator.

The outreach grant made it possible to provide a range of services. Middle school students and teachers received training to recognize and respond to heart attack situations through the Early Heart Attack Care Program. Community members received better access to health services and information, including walk-in services, general health education, parent education and health screenings for a variety of conditions such as elevated blood pressure and cholesterol. Women aged 60 and older gained access to an osteoporosis prevention program, which was eventually expanded to include younger women. Exercise and wellness programs for older women and others were also offered.

Innovative Solutions to Problems

A unique feature of the program was the child car seat inspection and training program. The consortium sponsored three car seat inspections that reached 183 people. Twenty inspectors were trained to assess the safety of child car seats.

Results

The services made possible by the grant reached more than 21,000 people in the tri-State area. Most recipients were children and teenagers under age 18. However, nearly 1,900 were persons aged 65 and older. The project's parenting program reached approximately 35 fathers and children, and the group for teen mothers served approximately 40 girls. About 55 people participated in various support groups. The project evaluation indicates that participants benefited from the services they received, and the program played an important role in promoting positive health behaviors.

Potential for Replication

An important lesson learned by the consortium from their experiences was recognition that programming must be based on local needs and interests. Programs that provide information and services that people want and appreciate generate more demand for additional services. It is also essential to consider convenience for the participants, such as nontraditional hours, when delivering health education and health promotion services.

Another important lesson was that project partners must be committed and willing to work together. They need to meet regularly, share data, highlight their successes, and work in close partnership to solve problems.

After the Grant

The consortium partners are considering a range of options for securing additional funding—both as a group and separately. Some programs have been incorporated into other local projects for support and continued benefit to the communities. Videos and other materials purchased through the grant can be used to provide continuing health promotion and education services.

Population Served

The Western Dairyland Rural Health Outreach Project was designed to serve a three-county area in west-central Wisconsin. Buffalo, Jackson, and Trempealeau counties are rural and have a low population density. The people who call this region home are predominantly Euro-American. However, approximately 4 percent of the population in Jackson County are American Indian. The counties targeted by the project have poverty rates that are higher than the State's rate of 10 percent (11.9 percent in Buffalo County, 14.7 percent in Jackson County, and 10.7 percent in Trempealeau County).

Services Offered

The main goals of the project were to increase access to reproductive health services, establish a children's dental sealant clinic for low-income children, and create healthy lifestyle and smoking cessation programs. The project also sought to implement a reproductive health education program in local schools.

To achieve these goals, the Western Dairyland Rural Health Outreach Project created a consortium of four organizations that share these common objectives. The Western Dairyland Economic Opportunity Council served as the consortium's coordinating body. Other members included the Buffalo County Public Health Department, the Jackson County Health Department, and the Trempealeau County Public Health Department.

The Western Dairyland Women's Health Center provided preconception and reproductive health services. Referrals came from county health departments, Women, Infants, and Children programs, the Head Start program, Western Dairyland's employment and training program, and other sources. Western Dairyland managed the Proactive Peer Support Telephone Network for Smoking Cessation and initially provided coordination for the children's dental component. After the first year, the county health departments assumed responsibility for coordinating the dental clinics services. They also offered healthy lifestyle programs and smoking cessation clinics. Trempealeau County Public Health Department spearheaded the creation of a Tobacco-Free Coalition because smoking cessation services were already available.

WISCONSIN

WESTERN DAIRYLAND RURAL HEALTH OUTREACH PROJECT
WESTERN DAIRYLAND ECONOMIC OPPORTUNITY COUNCIL
WHITEHALL, WI

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Patients of the Women's Health Center who are living at or below the poverty level receive services free of charge. Some patients pay for services based on a sliding scale. Other sources of payment include medical assistance programs and third-party insurers. The center expanded its hours of operation and provided patient education and counseling, medical exams, pap smears, sexually transmitted disease (STD) testing and treatment, pregnancy testing, contraceptives, and treatment of manageable conditions. Center staff went to local schools to educate youth on reproductive health, birth control, STDs, and other topics.

The Children's Dental Clinic provided sealants to low-income and uninsured children who were at 185 percent of the poverty level or below. The clinic was available in each county two times a year. Public health nurses from the county health departments coordinated the healthy lifestyle program.

Innovative Solutions to Problems

The smoking cessation telephone network recruited former smokers to volunteer to run the network, and a behavioral medicine specialist provided training for the recruits. While the program did not attract the expected number of participants, offering smoking cessation products did attract smokers and gave them more incentive to quit. In addition, Western Dairyland and the public health departments used grant funds to advertise in local newspapers and on radio stations, and to create a brochure that described the program's services. The brochure was made available to clients at the local public health departments.

Each day during National Healthy Weight Week, Buffalo County hosted an in-house program at the Court House that focused on a food group. Healthy snacks from that food group and recipes were offered to people visiting the Court House. During Public Health Week, displays that offered information on the project and other health information were set up at various sites throughout Buffalo County.

Results

During the course of the grant, 2,340 people received services at the Women's Health Center, and more than 400 children received care at the children's dental clinic. In addition, 852 people participated in the Healthy Lifestyle Education program, and 117 benefited from the project's smoking cessation services. An estimated 1,800 teenagers received reproductive

health education in local schools. Of those who received services or participated in various health education activities, 4,553 were female, and 970 were male.

Potential for Replication

This model is particularly relevant to rural communities with a large number of underserved residents who would benefit from reproductive health, education, and children's dental services. As noted above, communities that want to offer smoking cessation services may find that giving smoking cessation aids may increase participation in the program.

After the Grant

The Women's Health Center continues to provide reproductive and other health and support services to women throughout the area. Incoming funds are used to offset operating expenses. New revenues are helping to continue the center's activities. Public health agencies continue to provide nutrition counseling and education through their prevention grants. The State of Wisconsin has provided funding to ensure that dental services will be available to children in the three counties. Sealant materials are provided by the Wisconsin Dental Association, and local dentists are volunteering their time to provide dental care to low-income children.

CONTINUING EDUCATION FOR HEALTH PROFESSIONALS	*PROJECT NUMBER*
Emergency medical services personnel	
Emergency medical technicians	18, 32, 34, 38
Firefighters	32, 38
Paramedics	18, 32, 38
Emergency room personnel	
Nurses	7
Physicians	38
Social workers	1, 2, 7, 11, 41
Subject	
Survival	1, 2, 42

HEALTH PROMOTION/EDUCATION	*PROJECT NUMBER*
Health promotion/disease prevention (general)	1, 3, 7, 8, 15, 17, 35
Health promotion/disease prevention (specific)	
Anger management	42
Child abuse	42
CPR	3, 10, 12, 14, 32
Dementia	18, 43
Depression	17, 43
Diabetes	4, 5, 6, 10, 12, 21, 22
Drug abuse	16, 17, 21, 40
First aid	3, 12, 14
Mental health	1, 2, 11, 12, 21, 26, 35, 43
Nutrition	2, 3, 4, 5, 29, 36
Self-esteem	11, 16, 17, 20, 21
Sexuality	9, 11, 19, 20, 39
Smoking cessation	20, 35, 42, 45
Substance abuse	16, 17, 20, 21, 35, 40
Tobacco prevention	16, 17, 20, 21, 35, 40
Peer counseling	

POPULATION GROUP	*PROJECT NUMBER*
Adolescents	1, 2, 3, 4, 7, 8, 9, 11, 12, 16, 17, 20, 26, 37, 40, 41, 42, 44, 45

POPULATION GROUP (CONTINUED)	*PROJECT NUMBER*
Children	1, 2, 3, 4, 5, 7, 8, 9, 12, 13, 16, 20, 37, 41, 44, 45
Disabled	18, 24
Elderly	3, 6, 14, 15, 18, 27, 30, 40, 44
Infants	3, 4, 5, 9, 25, 41
Minorities	
African-American	1, 6, 19, 23
Amish	
Hispanic	5, 8, 10, 13, 14, 22, 26, 29, 30
Native American	3, 4, 6, 29, 36
Pregnant women and teens	9, 26, 39, 45
Women	5, 9, 22, 40, 45

SERVICES	*PROJECT NUMBER*
Advocacy	6, 11, 29
Case management	1, 2, 7, 8, 10, 11, 14, 16, 18, 21, 22, 28, 35
Counseling services	1, 2, 11, 16, 26, 41
Dental care	13, 23, 45
Emergency medical services	3, 7, 9, 10, 13, 34, 41
Health fairs	4, 8, 10, 15, 42
Immunizations	7, 8, 9, 10, 13, 39
Library	10, 12, 21

SERVICES (CONTINUED)	*PROJECT NUMBER*
Media coverage	10, 20, 14
Medicaid	7, 8, 9, 12, 13, 17, 23
Medicare	7, 8, 9, 12, 13, 17, 23
Mental health services	1, 2, 11
Preventive health care	1, 3, 4, 6, 7, 8, 9, 10, 11,14, 16, 22, 25, 27, 29, 30
Primary care	1, 3, 7, 8, 9, 10, 11, 12, 16, 23, 30
Public health	1, 8, 10, 28, 37
Referrals	1, 8, 10
Screenings (general)	1, 6, 9, 10, 12, 14, 18
Screenings (specific)	
Blood pressure	1, 6, 9, 10, 21, 44
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